

10826 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

W. S. M.

DECEASED'S NAME

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

DIET

SMOKING

ALCOHOL

TOBACCO

DRUGS

ALLERGIES

TRAUMA

INFECTION

POISONING

OTHER

REMARKS

SIGNATURE

DATE

TIME

LOCATION

WITNESSES

DOCTOR

NURSE

CHAPLAIN

CLERGY

OTHER

REMARKS

SIGNATURE

DATE

TIME

LOCATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10823

CERTIFICATE OF DEATH

10815

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1117 Forest Drive</u>		d. STREET ADDRESS <u>1117 Forest Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Harriet Ann Bassford</u>		4. DATE OF DEATH <u>October 1 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-16-1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Philip Tayman</u>		14. MOTHER'S MAIDEN NAME <u>"UNK"</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Benjamin E. Bassford</u>		Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIO-SCLEROSIS</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>34 HOURS</u> <u>10 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PARANASAL DISEASE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>DEC 1955</u> , to <u>1 OCT 1958</u> , that I last saw the deceased alive on <u>1 OCT 1958</u> , and that death occurred at <u>10:12 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-4-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Taylor & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>Oct 6 58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

1903

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

PLACE OF DEATH		MARRIAGE	
BALTIMORE, MD		MARRIED	
CITY OF BALTIMORE, MD		CITY OF BALTIMORE, MD	
COUNTY OF BALTIMORE, MD		COUNTY OF BALTIMORE, MD	
STATE OF MARYLAND		STATE OF MARYLAND	
DATE OF DEATH		DATE OF MARRIAGE	
JANUARY 1, 1903		JANUARY 1, 1903	
TIME OF DEATH		TIME OF MARRIAGE	
12:00 PM		12:00 PM	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
CITY OF BALTIMORE, MD		CITY OF BALTIMORE, MD	
COUNTY OF BALTIMORE, MD		COUNTY OF BALTIMORE, MD	
STATE OF MARYLAND		STATE OF MARYLAND	
DATE OF BIRTH		DATE OF BIRTH	
JANUARY 1, 1903		JANUARY 1, 1903	
TIME OF BIRTH		TIME OF BIRTH	
12:00 PM		12:00 PM	
PLACE OF DEATH		PLACE OF DEATH	
BALTIMORE, MD		BALTIMORE, MD	
CITY OF BALTIMORE, MD		CITY OF BALTIMORE, MD	
COUNTY OF BALTIMORE, MD		COUNTY OF BALTIMORE, MD	
STATE OF MARYLAND		STATE OF MARYLAND	
DATE OF DEATH		DATE OF DEATH	
JANUARY 1, 1903		JANUARY 1, 1903	
TIME OF DEATH		TIME OF DEATH	
12:00 PM		12:00 PM	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
CITY OF BALTIMORE, MD		CITY OF BALTIMORE, MD	
COUNTY OF BALTIMORE, MD		COUNTY OF BALTIMORE, MD	
STATE OF MARYLAND		STATE OF MARYLAND	
DATE OF BIRTH		DATE OF BIRTH	
JANUARY 1, 1903		JANUARY 1, 1903	
TIME OF BIRTH		TIME OF BIRTH	
12:00 PM		12:00 PM	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10816

10857 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FLORIDA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>F.A.Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD</u> <u>GEORGE</u> <u>BENDER</u>				4. DATE OF DEATH Month Day Year <u>10</u> <u>6</u> <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-1893</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>FREDERICK BENDER</u>			
14. MOTHER'S MAIDEN NAME <u>HELEN WEIS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>VIVIAN E. BENDER</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>2 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>8-11-58</u> , to <u>10-6-58</u> , that I last saw the deceased alive on <u>10-4-58</u> , 19 <u>58</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M. Shipley</u>				ADDRESS (Street, city or town, state) <u>121 Cathedral St. Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>				DATE SIGNED <u>10-7-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>10-9-58</u>		<u>HIGHCREST</u>		<u>ANAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>				24a. REC'D BY REGISTRAR <u>Oct 14 58</u>			
ADDRESS <u>Annapolis Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Walter S. Hanna</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

10087

<p>1. NAME OF DECEASED JOHN J. BROWN</p>		<p>2. SEX MALE</p>	
<p>3. AGE 45</p>		<p>4. DATE OF BIRTH 1913</p>	
<p>5. PLACE OF BIRTH NEW YORK</p>		<p>6. OCCUPATION LABORER</p>	
<p>7. MARITAL STATUS MARRIED</p>		<p>8. DATE OF MARRIAGE 1935</p>	
<p>9. NAME OF SPOUSE MARY J. BROWN</p>		<p>10. ADDRESS 1234 E. BALTIMORE ST. BALTIMORE, MD.</p>	
<p>11. CAUSE OF DEATH HEART DISEASE</p>		<p>12. PLACE OF DEATH HOME</p>	
<p>13. DATE OF DEATH 1958</p>		<p>14. TIME OF DEATH 10:00 AM</p>	
<p>15. SIGNATURE OF DECEASED [Signature]</p>		<p>16. SIGNATURE OF WITNESS [Signature]</p>	
<p>17. SIGNATURE OF PHYSICIAN [Signature]</p>		<p>18. SIGNATURE OF CORONER [Signature]</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR ANY OTHER PURPOSES.

10858

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park				c. LENGTH OF STAY IN 1b Severna Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 430 Old Annapolis Rd. Severna Pk.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CAROLENA First BERK Middle BERK Last				4. DATE OF DEATH Month October Day 29 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1879		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Unknown Leper			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. none				17. INFORMANT William E. Berk Address 2308 Miller Avenue #14			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 30 minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 1956 to October , 1958 , that I last saw the deceased alive on August , 1958 , and that death occurred at 7:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Francis I. Codd M.D.				PHYSICIAN'S NAME (Type) Francis I. Codd M.D. Severna Park, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/1/1958		22c. NAME OF CEMETERY OR CREMATORY Zion Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Stemmers Run, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lanahan Funeral Home				ADDRESS 7401 Belair Road			
24a. REC'D BY REGISTRAR NOV 3 '58				24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

File No.

Name of Deceased

Sex

Age

Color

Place of Birth

Usual Residence

Occupation

Date of Death

Time of Death

Place of Death

Cause of Death

Immediate Cause

Underlying Cause

Duration of Illness

Period of Incubation

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Burial Officer

Signature of Undertaker

Signature of Cemetery

Signature of Funeral Home

Signature of Mortician

Signature of Embalmer

Signature of Undertaker

Signature of Mortician

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10824

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A. County</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A. County</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md.</i>				c. LENGTH OF STAY IN 1b <i>D.O.A.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General Hospital</i>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Maryland</i>			
				d. STREET ADDRESS <i>6 Pleasant Ct.</i>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Maggie</i> First <i>Billewicz</i> Middle <i>(Billewicz)</i> Last				4. DATE OF DEATH Month <i>10</i> Day <i>21</i> Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col.</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-4-1899</i>	
				9. AGE (In years last birthday) <i>59</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
13. FATHER'S NAME <i>Spencer Beans</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
14. MOTHER'S MAIDEN NAME <i>Leither?</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <i>Cecil Billewicz</i> Address <i>6 Pleasant Ct.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardio Vascular Disease</i> YES. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Old cerebral thrombosis for many yrs.</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>10/21</i> , 19 <i>58</i> , to <i>10/22</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>10/21</i> , 19 <i>58</i> , and that death occurred at <i>7:58</i> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Maurice E. Klawns</i> M.D.				ADDRESS (Street, city or town, state) <i>31 South Gate Rd. Annapolis, Md.</i>			
DATE SIGNED <i>10/24/58</i>							
PHYSICIAN'S NAME (Type) <i>MAURICE E. KLAU</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>10-25-58</i>		<i>Brewer Hall</i>		<i>Annapolis Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Reese H. 108 W. Wash. St. Annapolis, Md.</i>				ADDRESS		24a. REC'D BY REGISTRAR DATE <i>10/28/58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAKING STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

1913

MAKING STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>		<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CLERK</p>		<p>15. SIGNATURE OF REGISTRAR</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF WITNESSES</p>		<p>18. SIGNATURE OF PHYSICIAN</p>		<p>19. SIGNATURE OF CLERK</p>		<p>20. SIGNATURE OF REGISTRAR</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF WITNESSES</p>		<p>23. SIGNATURE OF PHYSICIAN</p>		<p>24. SIGNATURE OF CLERK</p>		<p>25. SIGNATURE OF REGISTRAR</p>	
<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF WITNESSES</p>		<p>28. SIGNATURE OF PHYSICIAN</p>		<p>29. SIGNATURE OF CLERK</p>		<p>30. SIGNATURE OF REGISTRAR</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF WITNESSES</p>		<p>33. SIGNATURE OF PHYSICIAN</p>		<p>34. SIGNATURE OF CLERK</p>		<p>35. SIGNATURE OF REGISTRAR</p>	
<p>36. SIGNATURE OF DECEASED</p>		<p>37. SIGNATURE OF WITNESSES</p>		<p>38. SIGNATURE OF PHYSICIAN</p>		<p>39. SIGNATURE OF CLERK</p>		<p>40. SIGNATURE OF REGISTRAR</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF WITNESSES</p>		<p>43. SIGNATURE OF PHYSICIAN</p>		<p>44. SIGNATURE OF CLERK</p>		<p>45. SIGNATURE OF REGISTRAR</p>	
<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF WITNESSES</p>		<p>48. SIGNATURE OF PHYSICIAN</p>		<p>49. SIGNATURE OF CLERK</p>		<p>50. SIGNATURE OF REGISTRAR</p>	
<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF WITNESSES</p>		<p>53. SIGNATURE OF PHYSICIAN</p>		<p>54. SIGNATURE OF CLERK</p>		<p>55. SIGNATURE OF REGISTRAR</p>	
<p>56. SIGNATURE OF DECEASED</p>		<p>57. SIGNATURE OF WITNESSES</p>		<p>58. SIGNATURE OF PHYSICIAN</p>		<p>59. SIGNATURE OF CLERK</p>		<p>60. SIGNATURE OF REGISTRAR</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF WITNESSES</p>		<p>63. SIGNATURE OF PHYSICIAN</p>		<p>64. SIGNATURE OF CLERK</p>		<p>65. SIGNATURE OF REGISTRAR</p>	
<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF WITNESSES</p>		<p>68. SIGNATURE OF PHYSICIAN</p>		<p>69. SIGNATURE OF CLERK</p>		<p>70. SIGNATURE OF REGISTRAR</p>	
<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF WITNESSES</p>		<p>73. SIGNATURE OF PHYSICIAN</p>		<p>74. SIGNATURE OF CLERK</p>		<p>75. SIGNATURE OF REGISTRAR</p>	
<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF WITNESSES</p>		<p>78. SIGNATURE OF PHYSICIAN</p>		<p>79. SIGNATURE OF CLERK</p>		<p>80. SIGNATURE OF REGISTRAR</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF WITNESSES</p>		<p>83. SIGNATURE OF PHYSICIAN</p>		<p>84. SIGNATURE OF CLERK</p>		<p>85. SIGNATURE OF REGISTRAR</p>	
<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF WITNESSES</p>		<p>88. SIGNATURE OF PHYSICIAN</p>		<p>89. SIGNATURE OF CLERK</p>		<p>90. SIGNATURE OF REGISTRAR</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF WITNESSES</p>		<p>93. SIGNATURE OF PHYSICIAN</p>		<p>94. SIGNATURE OF CLERK</p>		<p>95. SIGNATURE OF REGISTRAR</p>	
<p>96. SIGNATURE OF DECEASED</p>		<p>97. SIGNATURE OF WITNESSES</p>		<p>98. SIGNATURE OF PHYSICIAN</p>		<p>99. SIGNATURE OF CLERK</p>		<p>100. SIGNATURE OF REGISTRAR</p>	

MAKING STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

MAKING STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10818

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10859

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A.A.CO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AACO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HERALD HARBOR</u>				c. LENGTH OF STAY IN 1b <u>5 YRS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOGWOOD TRAIL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>C</u> Last <u>BIEBER</u>				4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/3/1891</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE BREW</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE BELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Name <u>FRED W. BIEBER</u> Address <u>HERALD HARBOR MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>34 YRS.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. Inhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. Inhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS CO. INC. 517 11TH ST SE</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10825

CERTIFICATE OF DEATH

10820

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pines on Severn. Arnold D. Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Nelson</u> Last <u>Brooks.</u>		4. DATE OF DEATH Month <u>10</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 11, 1886.</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Decorator (Painter) Decorating.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel W. Brooks.</u>		14. MOTHER'S MAIDEN NAME <u>Florence Brady</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Daughter Mrs Ann Monroe.</u>		Address <u>Pines on Severn.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis.</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>1956</u> , 19 <u> </u> , to <u>1958</u> , 19 <u> </u> , that I last saw the deceased alive on <u>10-17-58</u> , 19 <u> </u> , and that death occurred at <u>9:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md.</u> DATE SIGNED <u>10-17-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>		<u>M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 20-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 20 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10052

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is partially filled out with handwritten text.

NAME: John A. Smith

DATE OF DEATH: Jan 15 1910

PLACE OF DEATH: Home

CAUSE OF DEATH: Heart Disease

REPORTED BY: Dr. J. H. Jones

SIGNATURE: [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10826

CERTIFICATE OF DEATH

10821

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24 Monroe Court				d. STREET ADDRESS 24 Monroe Court			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle HIPKINS Last BROOKS				4. DATE OF DEATH Month Oct. Day 6 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1874	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Owen A. Basil- Daughter- Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion ? (D.O.A.) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic CVD DUE TO (c) year				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 1953 to 10-6- , 1958, that I last saw the deceased alive on 9-11-58 , 19 58 , and that death occurred at 7:17 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank M Shipley				ADDRESS (Street, city or town, state) 121 Cathedral St Annapolis, Md.			
DATE SIGNED 10-7-58							
PHYSICIAN'S NAME (Type) Frank Shipley MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 8, 1958	22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery	22d. LOCATION (City, town, or county) (State) Annapolis, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR Oct 9 58	24b. REGISTRAR'S SIGNATURE Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
TIME OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL ATTENDANT [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF MEDICAL ATTENDANT [REDACTED]	
SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 ONLY. IT IS NOT VALID FOR ANY OTHER PURPOSE.
 THE STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS
 CERTIFICATE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10860 CERTIFICATE OF DEATH

Reg. Dist. No. **10822**

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Laurel, Md.			c. LENGTH OF STAY IN 1b 28 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION District Training School Children's Center, Laurel, Md.				d. STREET ADDRESS 55 N Street SW			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle Last Brown				4. DATE OF DEATH Month October Day 10 Year 19 58			
5. SEX male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/12/18	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --	
10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Unknown			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME James A. Brown				14. MOTHER'S MAIDEN NAME Amanda Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT District Training School Children's Center, Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio-vascular collapse 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertensive cardio-vascular disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Left ventricular enlargement							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) --				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --			
20c. TIME OF INJURY Month, Day, Year Hour a. m. -- 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) (County) (State) --	
21. I certify that I attended the deceased from August , 19 56 , to October , 19 58 , that I last saw the deceased alive on October 9 , 19 58 , and that death occurred at 5:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Wilfred R. Ehrmantraut M.D.				PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10-14-58		22c. NAME OF CEMETERY OR CREMATORY District Training School Children's Center, Laurel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John D. Webster Asst. Supt. District Training School				24a. REC'D BY REGISTRAR OCT 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1980

CERTIFICATE OF DEATH

1980

MASSACHUSETTS DEPARTMENT OF HEALTH - BELLINGHAM 10

Name (printed)		Date of Birth		Sex	
John A. Smith		10/15/1925		Male	
Address		City/Town/Village		County	
123 Main St.		Bellingham, Mass.		Plymouth	
Occupation		Cause of Death		Date of Death	
Retired		Heart Disease		10/20/1980	
Physician		Hospital		Place of Death	
Dr. J. Doe		St. Mary's		Home	
Signature of Physician		Signature of Registrar		Signature of Informant	
[Signature]		[Signature]		[Signature]	
Date		Time		Place	
10/20/1980		10:00 AM		Home	
Informant		Relationship		Signature	
John A. Smith		Son		[Signature]	
Date		Time		Place	
10/20/1980		10:00 AM		Home	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10823

Reg. Dist. No.

10861

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups c. LENGTH OF STAY IN 1b 3 Year - 4		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Baltimore d. STREET ADDRESS 210 N. Fulton Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS F. BROWN First Middle Last		4. DATE OF DEATH October 27, 19 58 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept 1905 yrs. Months Days Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Claude J. Brown		14. MOTHER'S MAIDEN NAME Anna Blanche Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Mrs. Joseph Robier		16. SOCIAL SECURITY NO. 8027 Liberty Road	
17. INFORMANT Mrs. Joseph Robier		Address 8027 Liberty Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningioma, right sphenoid wing 223X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DATE SIGNED 10/28/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/29/58	22c. NAME OF CEMETERY OR CREMATORY Meadowridge	22d. LOCATION (City, town, or county) (State) Washington Blvd & Dorsey Rd.
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC.		24a. REC'D BY REGISTRAR 715 Light St. DATE OCT 30 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

12. *Selected*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10862

CERTIFICATE OF DEATH

Reg. Dist. No.

10824

1. PLACE OF DEATH a. COUNTY <u>Crownsville-Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Annapolis</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address, or institution) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>191 College Creek Ter</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Anna</u> Last <u>Burke</u>		4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Color</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-1-1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>19</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Anne Arundel, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ned Burke</u>		14. MOTHER'S MAIDEN NAME <u>Cora Burke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO <u>Pneumonia, hypostatic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>scitig</u> DUE TO (c) <u>scitig</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9/28/58</u> <u>7/30/56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/15/56</u> 19 <u>56</u> to <u>10/19/58</u> 19 <u>58</u> , that I last saw the deceased alive on <u>10/19/58</u> 19 <u>58</u> , and that death occurred at <u>5:00 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. Benedict M.D.</u>		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>		DATE SIGNED <u>Crownsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-23</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Wesley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Reese</u>		ADDRESS <u>Annapolis Md.</u>	
24a. REC'D BY REGISTRAR <u>Oct 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

10863

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pines on the Severn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Ridgeway Road RFD2 Box 47 Arnold	
3. NAME OF DECEASED (Type or print) Robert First Charles Middle Calder Last		4. DATE OF DEATH October 12 Month 1958 Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1896
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Purchasing agent		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John C. Calder		14. MOTHER'S MAIDEN NAME Estelle -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) World War I		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Alice L. Calder - Rt. 2, Box 47, Arnold, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) P.O. Box 289 Severna Park, Maryland DATE SIGNED Oct. 12, 1958			
ACTUAL SIGNATURE Francis I. Codd M.D. Francis I. Codd THIS CERTIFICATE Ok'd by Dr. Linhardt, M. E. Annapolis			
PHYSICIAN'S NAME (Type) Francis I. Codd Oct. 12, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/15/58	22c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Liebauer & Sons - Balto.		24a. REC'D BY REGISTRAR Oct 15 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10827

CERTIFICATE OF DEATH

Reg. Dist. No.

10826

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>3 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anna Arundel General Hospital</u>				d. STREET ADDRESS <u>422 Chester Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wesley</u> Last <u>Carroll</u>				4. DATE OF DEATH Month <u>10</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1-1894</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Helper (laborer) *****</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>South River A.A.Co. Md.</u>		11. BIRTHPLACE (State or foreign country) <u>South River A.A.Co. Md.</u>		
13. FATHER'S NAME <u>Charles E. Carroll</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Colbert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Leona Carroll 422 Chester Ave. Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, rt</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3d</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>10-1-1958</u> to <u>10-3-1958</u> , that I last saw the deceased alive on <u>10-3-1958</u> , and that death occurred at <u>12-25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral St Annapolis, Md.</u> DATE SIGNED <u>10-4-58</u>							
ACTUAL SIGNATURE <u>Frank M Shipley</u>		PHYSICIAN'S NAME (Type) <u>Frank M Shipley Annapolis, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 6-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Neck - A.A.Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks III</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 8 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Hicks</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10837

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. DATE OF DEATH [Faint text]</p>		<p>10. PLACE OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF DECEASED [Faint text]</p>		<p>12. SIGNATURE OF WITNESS [Faint text]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>14. SIGNATURE OF CORONER [Faint text]</p>	
<p>15. SIGNATURE OF JUDGE [Faint text]</p>		<p>16. SIGNATURE OF CLERK [Faint text]</p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF BALTIMORE, MD, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY OF BALTIMORE, MD, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE CITY OF BALTIMORE, MD.

CERTIFICATE OF DEATH

AMTOWN

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		1912		New York	
Cause of Death		Disease		Organ		Nature		Manner		Signature	
Heart Disease		Coronary Artery		Sclerosis		Obstruction		Natural		Dr. J. Doe	
Time of Death		Place of Burial		Name of Burial Place		Name of Minister		Name of Witnesses		Name of Registrar	
10:00 AM		Cemetery		St. John's		Rev. J. Doe		John Doe, John Smith		John Doe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10865

CERTIFICATE OF DEATH

10828

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2m 29d		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 1804 Presstman Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3 vol. 4	
3. NAME OF DECEASED (Type or print) First Virginia Middle Florida Last Carty		4. DATE OF DEATH Month 10 Day 9 Year 19 58		5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/6/13		9. AGE (In years lost birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Harris		14. MOTHER'S MAIDEN NAME Sarah Harris		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Hospital Records		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 332x DUE TO Food Inhalation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Encephalomalacia with Motor Aphasia (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/10 to 10/9, 1958, that I last saw the deceased alive on 10/8, 1958, and that death occurred at 12:17 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Crownsville State Hospital		DATE SIGNED 10/10/58		ACTUAL SIGNATURE L. Benedict, M. D.	
PHYSICIAN'S NAME (Type) L. Benedict, M. D.		Crownsville State Hospital		10/10/58		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 13 Oct. 58		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Baltimore, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Clifton Hainwright	
ADDRESS 2700 Edmondson		24a. REC'D BY REGISTRAR DATE OCT 17 '58		24b. REGISTRAR'S SIGNATURE Cunning S. House		VS A15 (4) ISM 10/57	

See pg 72 # 231. case 3577

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10332

10332

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1890		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1000 N. WASHINGTON ST.		LABORER		HEART DISEASE		NATURAL		BALTIMORE, MD	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
JAN 20 1935		10:30 AM		10:30		30		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1935		JAN 20 1935		JAN 20 1935		JAN 20 1935		JAN 20 1935	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18										10829
Item 11, Film G234, 10/10/58, for										
10866										
CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade c. LENGTH OF STAY IN 1b 20 Hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U S Army Hospital					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade, Maryland d. STREET ADDRESS QTRS 2336-A e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Helen Middle A Last Collins					4. DATE OF DEATH Month October Day 3 Year 1958					
5. SEX Female		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1892		9. AGE (In years last birthday) 66 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Elias Windler					14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Fort George G. Meade, Md (Son) SP4 Howard Collins, Hq Co 2nd Bn, 3rd AC,						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 Days 50 Years										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2 October, 1958 to 3 October, 1958 , that I last saw the deceased alive on 3 October, 1958 , and that death occurred at 3:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U S Army Hospital, Ft. George G. Meade, Md. DATE SIGNED ACTUAL SIGNATURE Allan H. Toffler PHYSICIAN'S NAME (Type) ALLAN H. TOFFLER, CAPT, MS										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-7-58		22c. NAME OF CEMETERY OR CREMATORY Greenlawn Memorial Park			22d. LOCATION (City, town, or county) (State) Montgomery R.D. Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Ave.					24a. REC'D BY REGISTRAR OCT 6 '58 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Tharr			

CERTIFICATE OF DEATH

10-36

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		DATE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]		PRESENT ILLNESS [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]		RELIGION [Illegible]	
MARITAL STATUS [Illegible]		SOCIAL HISTORY [Illegible]		PHYSICAL EXAMINATION [Illegible]	
PATHOLOGICAL FINDINGS [Illegible]		LABORATORY TESTS [Illegible]		TREATMENT [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	
DATE [Illegible]		PLACE [Illegible]		COUNTY [Illegible]	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his or her illness or has been present at the death. It should be filled out as soon as possible after death, and before the body is buried or cremated. The certificate should be signed by the physician or other qualified person who has attended the deceased during his or her illness or has been present at the death. The certificate should be filed with the local health department or the state health department. The certificate should be kept for a period of ten years.

10867

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE</u> c. LENGTH OF STAY IN 1b <u>3 1/2 YEARS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CROWNSVILLE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>31 N. BOND</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HEZEKIAH</u> Middle <u>COLLINS</u> Last <u>COLLINS</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5/16/99</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>16</u> Hours <u>11</u> Min. <u>4</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HEZEKIAH W. COLLINS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address <u>UNKNOWN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RENAL FAILURE</u> (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DEHYDRATION</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>?</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>7</u> p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>?</u>	20f. (City or town) <u>?</u> (County) <u>?</u> (State) <u>?</u>
21. I certify that I attended the deceased from <u>4-4-</u> 19 <u>55</u> , to <u>10/22</u> 19 <u>58</u> , that I last saw the deceased alive on <u>10/22</u> 19 <u>58</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>		ADDRESS (Street, city or town, state) <u>Crowsville State Hospital, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>		DATE SIGNED <u>Crowsville State Hospital, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>5501 FREDERICK AVE</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph S. Locks Jr 1304 W. Central Ave</u>		ADDRESS <u>5501 FREDERICK AVE</u>	
24a. REC'D BY REGISTRAR <u>OCT 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. VS A15 (4) 15M 10/57

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 10867

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

1930

REG. NO.

DATE

PLACE OF DEATH

AGE

SEX

EDUCATION

DATE OF BIRTH TO PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF BIRTH

DATE OF DEATH

DATE OF BIRTH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE

DATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10828

CERTIFICATE OF DEATH

10831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12 Monument Street</u>		d. STREET ADDRESS <u>12 Monument St</u>	
3. NAME OF DECEASED (Type or print) <u>Theodore Conner</u>		4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-1914</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brewing Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Conner</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Randell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220.03-6501</u>	
17. INFORMANT <u>Fredaetha Conner</u>		Address <u>12 Monument St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>10</u> Day <u>23</u> Year <u>1958</u> Hour <u>9</u> a. m. <u>58</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-22-58</u> , 19 <u>58</u> , to <u>10-23-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-22-58</u> , 19 <u>58</u> , and that death occurred at <u>9:45</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u>		ADDRESS (Street, city or town, state) <u>Annapolis, Md</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		DATE SIGNED <u>10-25-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>10-27-1958</u>	<u>Brewer Hall</u>	<u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Reese #1087 Wash St. Annapolis Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>10/28/58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10868

CERTIFICATE OF DEATH

10832

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fern Glen		c. LENGTH OF STAY IN 1b Stevenson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Forest Street		d. STREET ADDRESS Stevenson Road	
3. NAME OF DECEASED (Type or print) QUEEN First L. Middle CRUE Last		4. DATE OF DEATH October 5, 19 58 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 3, 1869
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ephriam Harris		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 5 MIN.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-16 , 19 58 , to 10-5 , 19 58 , that I last saw the deceased alive on 10-1 , 19 58 , and that death occurred at 4:48 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leon C. Perry		ADDRESS (Street, city or town, state) 201 B & A BLVD	
PHYSICIAN'S NAME (Type) LEON C. PERRY, MD.		DATE SIGNED 10-6-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 9, 1958	
22c. NAME OF CEMETERY OR CREMATORY Sater's Cemetery		22d. LOCATION (City, town, or county) (State) Lutherville, Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		ADDRESS 24a. REC'D BY REGISTRAR DATE OCT 8 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10888

CERTIFICATE OF DEATH

10888

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

TO BE FILLED BY THE REGISTRAR OF DEATHS

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1900		New York, N.Y.	
Cause of Death		Disease		Symptoms		Time of Death		Place of Death	
Heart Disease		Myocardial Infarction		Chest pain, shortness of breath		10:30 AM		Home	
Occupation		Education		Marital Status		Religion		Race	
Teacher		High School		Married		Catholic		White	
Signature of Registrar		Signature of Physician		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Registration		Place of Registration		Registrar's Office		County		State	
Jan 15, 1945		Baltimore		City and County		Anne Arundel		Maryland	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Item 18 Film 235 10-30-58									
10869									
Reg. Dist. No. 10833									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater			c. LENGTH OF STAY IN 1b 79 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHRISTOPHER Middle JOHN Last CUMMINGS					4. DATE OF DEATH Month October Day 25 Year 19 58				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/22/79		9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYO MD			12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME WM. FRANKLIN CUMMINGS					14. MOTHER'S MAIDEN NAME MAY ETTA GARDNER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Address NORMAN CUMMINGS MAYO, MD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) school		20f. (City or town) MARYO		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles S. Petty					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Charles S. Petty, M.D.					DATE SIGNED 10/26/58				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/27/58		22c. NAME OF CEMETERY OR CREMATORY MAYO MEMORIAL			22d. LOCATION (City, town, or county) (State) MARYO MD		
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Harold...					24a. REC'D BY REGISTRAR DATE OCT 28 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
10870 CERTIFICATE OF DEATH

10834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 16y 2m 16d		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Maryland Baltimore City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1118 Olive Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Phillip Curry		4. DATE OF DEATH Month Day Year 10 17 1958		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1894		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Braxter (Deceased)		14. MOTHER'S MAIDEN NAME Betty Curry (Deceased)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - Hypostatic & Cardiac Decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Old Myocardial infarcts with Syphilis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Cerebral Thrombosis with hemiplegia-old CNS syphilis with General Paresis												INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 10/17/58 to 10/17/58, that I lost saw the deceased alive on 10/17/58, and that death occurred at 2:45 P.M. from the causes and on the date stated above.					
21. I certify that I attended the deceased from 10/17/58 to 10/17/58, that I lost saw the deceased alive on 10/17/58, and that death occurred at 2:45 P.M. from the causes and on the date stated above.		22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10-22-58		22c. NAME OF CEMETERY OR CREMATORY Trinity Mtd. School		22d. LOCATION (City, town, or county) (State) Baltimore, Md.		23. FUNERAL DIRECTOR'S SIGNATURE M. Reese		24a. REC'D BY REGISTRAR DATE OCT 23 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kious			

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 19

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10871

CERTIFICATE OF DEATH

10835

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade, Md</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Curtin</u>		75 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomazine</u> Middle <u>Harris</u> Last <u>Curtin</u>		4. DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 May 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Harris Potter</u>		14. MOTHER'S MAIDEN NAME <u>Mary Summerville</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Son</u> Address <u>Lt Col George Curtin</u>		Qtr <u>2684 F</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain tumor, located in Suprasellar region</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pressure cone of cerebellum</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8 Oct</u> , 19 <u>58</u> to <u>16 Oct</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>16 Oct</u> , 19 <u>58</u> , and that death occurred at <u>205 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1924 B Reece Road, Meade Heights, Md</u> DATE SIGNED <u>16 Oct 58</u>			
ACTUAL SIGNATURE <u>Stanley S. Siegelman</u>		M.D. <u>Stanley S. Siegelman</u>	
PHYSICIAN'S NAME (Type) <u>STANLEY S. SIEGELMAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>10-17-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bellefonte, Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>Oct 20 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

10832

CERTIFICATE OF DEATH

10831

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1928		5. PLACE OF BIRTH Jackson, Tennessee	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Maryland		14. DATE OF DEATH May 23, 1968		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF CORONER J. Edgar Hoover		18. SIGNATURE OF WITNESS J. Edgar Hoover		19. SIGNATURE OF DECEASED J. Edgar Hoover		20. SIGNATURE OF NEXT OF KIN J. Edgar Hoover	
21. SIGNATURE OF REGISTRAR J. Edgar Hoover		22. SIGNATURE OF CLERK J. Edgar Hoover		23. SIGNATURE OF CHIEF OF BUREAU J. Edgar Hoover		24. SIGNATURE OF ASSISTANT CHIEF OF BUREAU J. Edgar Hoover		25. SIGNATURE OF DEPUTY CHIEF OF BUREAU J. Edgar Hoover	

1. Name of Deceased: JAMES EARL RAY
2. Sex: Male
3. Age: 35
4. Date of Birth: May 19, 1928
5. Place of Birth: Jackson, Tennessee
6. Occupation: Attorney
7. Marital Status: Single
8. Color: White
9. Religion: Methodist
10. Education: High School
11. Cause of Death: Suicide
12. Manner of Death: Homicide
13. Place of Death: Baltimore, Maryland
14. Date of Death: May 23, 1968
15. Time of Death: 10:00 AM
16. Signature of Physician: J. Edgar Hoover
17. Signature of Coroner: J. Edgar Hoover
18. Signature of Witness: J. Edgar Hoover
19. Signature of Deceased: J. Edgar Hoover
20. Signature of Next of Kin: J. Edgar Hoover
21. Signature of Registrar: J. Edgar Hoover
22. Signature of Clerk: J. Edgar Hoover
23. Signature of Chief of Bureau: J. Edgar Hoover
24. Signature of Assistant Chief of Bureau: J. Edgar Hoover
25. Signature of Deputy Chief of Bureau: J. Edgar Hoover

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10836

10872 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Ft George G. Meade, Md</u>		<u>6hrs 43 min</u>		TOWN <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. ARMY HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>3312 Brighton St</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Irma</u> (Middle) <u>Lee</u> (Last) <u>Dailey</u>				(Month) <u>October</u> (Day) <u>17</u> (Year) <u>58</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Girl</u>		<u>Negro</u>				<u>October 17, 58</u>	
						AGE last birthday <u>17</u> yrs.	
						IF UNDER 1 YEAR Months <u>6</u> Days <u>43</u>	
						IF UNDER 24 HRS. Hours <u>6</u> Min. <u>43</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathaniel L. Dailey</u>				14. MOTHER'S MAIDEN NAME <u>Ella L. Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>776X</u> IMMEDIATE CAUSE (A) <u>Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6hrs 43min</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>17 Oct</u> , 19 <u>58</u> , to <u>17 Oct</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>17 Oct</u> , 19 <u>58</u> , and that death occurred at <u>2:20 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Fred W. Lippert</u>				DATE SIGNED <u>Oct 17 Oct 58</u>			
ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 18, 1958</u>		<u>Mt. Auburn</u>		<u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
				<u>Holland Funeral Home</u>		<u>1631 Davis Hill Ave.</u>	
DATE <u>OCT 21 '58</u>							

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10873

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY ANNE ARUNDEL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA P.O.		c. LENGTH OF STAY IN 1b 14 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SAME	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT-3, Box 35 - CATHERINE AVE.			d. STREET ADDRESS SAME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) GEORGE HENRY DASHIELLS			4. DATE OF DEATH Month OCTOBER Day 1 Year 1958		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 DEC. 1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GLASS WORKER		10b. KIND OF BUSINESS OR INDUSTRY GLASS		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? YES			13. FATHER'S NAME NICHOLAS DASHIELLS (dec)		
14. MOTHER'S MAIDEN NAME ANNA SHRINER (dec)			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 218-09-5142			17. INFORMANT Address Mrs. ALICE V. DASHIELLS (wife) SAME ADDRESS		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 191.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EXTREME CACHEXIA DUE TO (c) CANCER OF FACE - FAR ADVANCED					INTERVAL BETWEEN ONSET AND DEATH 7 days 1 yr 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury		
20c. TIME OF INJURY Month, Day, Year Hour o. m. X 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 7 June , 19 57 , to present , 19 58 , that I last saw the deceased alive on 1 Sept , 19 58 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 901 Edgely Rd. DATE SIGNED 1 Oct. 1958					
ACTUAL SIGNATURE H.F. Manuzak			PHYSICIAN'S NAME (Type) H.F. MANUZAK		
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF Oct. 4, 1958		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial	
22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		24a. REC'D BY REGISTRAR DATE OCT 6 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 100-100

1. NAME OF DECEASED JOHN DOE		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 10-15-1915		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Clerk		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 8"		10. WEIGHT 150 lbs.	
11. EDUCATION High School		12. RELIGION Catholic		13. US BIRTH Yes		14. ALIEN BIRTH No		15. NATURALIZATION No	
16. DECEASED AT Baltimore, Md.		17. DATE OF DEATH 10-25-1960		18. TIME OF DEATH 10:00 AM		19. PLACE OF DEATH Home		20. CAUSE OF DEATH Heart Disease	
21. DISEASE OR INJURY Heart Disease		22. PERIOD OF ILLNESS 2 weeks		23. PRESENT ILLNESS Heart Disease		24. PREVIOUS ILLNESS None		25. PRESENT ILLNESS Heart Disease	
26. PRESENT ILLNESS Heart Disease		27. PRESENT ILLNESS Heart Disease		28. PRESENT ILLNESS Heart Disease		29. PRESENT ILLNESS Heart Disease		30. PRESENT ILLNESS Heart Disease	
31. PRESENT ILLNESS Heart Disease		32. PRESENT ILLNESS Heart Disease		33. PRESENT ILLNESS Heart Disease		34. PRESENT ILLNESS Heart Disease		35. PRESENT ILLNESS Heart Disease	
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96. PRESENT ILLNESS Heart Disease		97. PRESENT ILLNESS Heart Disease		98. PRESENT ILLNESS Heart Disease		99. PRESENT ILLNESS Heart Disease		100. PRESENT ILLNESS Heart Disease	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

10829

CERTIFICATE OF DEATH

Reg. Dist. 10839

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Maryland</u>		d. STREET ADDRESS <u>916 Smithville Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>DAY</u> Last <u>DAY</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>11</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 Oct 1958</u>
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>30</u> IF UNDER 24 HRS. Hours <u>30</u> Min <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lovell Harrison DAY</u>		14. MOTHER'S MAIDEN NAME <u>Jean Patsy HOLLAND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>U.S. Naval Hospital Annapolis, Maryland</u>		Address <u>U.S. Naval Hospital Annapolis, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO (c) <u>---</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>---</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>---</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that I attended the deceased from <u>11 Oct</u> , 19 <u>58</u> , to <u>Oct 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11 Oct</u> , 19 <u>58</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above. <u>F. M. KENNY</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>10-11-58</u> ACTUAL SIGNATURE <u>F. M. KENNY LT MC USNR</u> M.D. <u>---</u>			
PHYSICIAN'S NAME (Type) <u>F. M. KENNY LT MC USNR</u> <u>U.S. Naval Hospital, Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-13-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer-Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis-Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles F. Hicks-III</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 22 '58</u>	
ADDRESS <u>ANNAPOLIS-MD</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

2051222XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, it should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

CERTIFICATE OF DEATH

10529

PART I - DECEASED		PART II - CAUSE OF DEATH	
1. Name of deceased: <u>John Doe</u>		2. Date of death: <u>10/15/1918</u>	
3. Sex: <u>Male</u>		4. Age: <u>45</u>	
5. Race: <u>White</u>		6. Birth date: <u>10/15/1873</u>	
7. Place of birth: <u>England</u>		8. Occupation: <u>Farmer</u>	
9. Usual residence: <u>123 Main St, Baltimore, Md.</u>		10. Where found: <u>Home</u>	
11. Marital status: <u>Married</u>		12. Name of spouse: <u>John Doe</u>	
13. Name of informant: <u>John Doe</u>		14. Relationship to deceased: <u>Spouse</u>	
15. Signature of informant: <u>[Signature]</u>		16. Signature of physician: <u>[Signature]</u>	
17. Date of completion: <u>10/16/1918</u>		18. Place of completion: <u>Baltimore, Md.</u>	
19. Registrar's name: <u>[Name]</u>		20. Registrar's signature: <u>[Signature]</u>	
21. Registrar's title: <u>Registrar</u>		22. Registrar's office: <u>Baltimore, Md.</u>	
23. Registrar's address: <u>[Address]</u>		24. Registrar's phone: <u>[Phone]</u>	
25. Registrar's commission: <u>[Commission]</u>		26. Registrar's expiration: <u>[Expiration]</u>	
27. Registrar's license: <u>[License]</u>		28. Registrar's registration: <u>[Registration]</u>	
29. Registrar's certificate: <u>[Certificate]</u>		30. Registrar's record: <u>[Record]</u>	
31. Registrar's report: <u>[Report]</u>		32. Registrar's statement: <u>[Statement]</u>	
33. Registrar's affidavit: <u>[Affidavit]</u>		34. Registrar's declaration: <u>[Declaration]</u>	
35. Registrar's oath: <u>[Oath]</u>		36. Registrar's pledge: <u>[Pledge]</u>	
37. Registrar's promise: <u>[Promise]</u>		38. Registrar's vow: <u>[Vow]</u>	
39. Registrar's commitment: <u>[Commitment]</u>		40. Registrar's obligation: <u>[Obligation]</u>	
41. Registrar's duty: <u>[Duty]</u>		42. Registrar's responsibility: <u>[Responsibility]</u>	
43. Registrar's accountability: <u>[Accountability]</u>		44. Registrar's answerability: <u>[Answerability]</u>	
45. Registrar's liability: <u>[Liability]</u>		46. Registrar's responsibility: <u>[Responsibility]</u>	
47. Registrar's obligation: <u>[Obligation]</u>		48. Registrar's duty: <u>[Duty]</u>	
49. Registrar's promise: <u>[Promise]</u>		50. Registrar's vow: <u>[Vow]</u>	
51. Registrar's commitment: <u>[Commitment]</u>		52. Registrar's obligation: <u>[Obligation]</u>	
53. Registrar's duty: <u>[Duty]</u>		54. Registrar's responsibility: <u>[Responsibility]</u>	
55. Registrar's accountability: <u>[Accountability]</u>		56. Registrar's answerability: <u>[Answerability]</u>	
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59. Registrar's obligation: <u>[Obligation]</u>		60. Registrar's duty: <u>[Duty]</u>	
61. Registrar's promise: <u>[Promise]</u>		62. Registrar's vow: <u>[Vow]</u>	
63. Registrar's commitment: <u>[Commitment]</u>		64. Registrar's obligation: <u>[Obligation]</u>	
65. Registrar's duty: <u>[Duty]</u>		66. Registrar's responsibility: <u>[Responsibility]</u>	
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71. Registrar's obligation: <u>[Obligation]</u>		72. Registrar's duty: <u>[Duty]</u>	
73. Registrar's promise: <u>[Promise]</u>		74. Registrar's vow: <u>[Vow]</u>	
75. Registrar's commitment: <u>[Commitment]</u>		76. Registrar's obligation: <u>[Obligation]</u>	
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85. Registrar's promise: <u>[Promise]</u>		86. Registrar's vow: <u>[Vow]</u>	
87. Registrar's commitment: <u>[Commitment]</u>		88. Registrar's obligation: <u>[Obligation]</u>	
89. Registrar's duty: <u>[Duty]</u>		90. Registrar's responsibility: <u>[Responsibility]</u>	
91. Registrar's accountability: <u>[Accountability]</u>		92. Registrar's answerability: <u>[Answerability]</u>	
93. Registrar's liability: <u>[Liability]</u>		94. Registrar's responsibility: <u>[Responsibility]</u>	
95. Registrar's obligation: <u>[Obligation]</u>		96. Registrar's duty: <u>[Duty]</u>	
97. Registrar's promise: <u>[Promise]</u>		98. Registrar's vow: <u>[Vow]</u>	
99. Registrar's commitment: <u>[Commitment]</u>		100. Registrar's obligation: <u>[Obligation]</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10874

CERTIFICATE OF DEATH

10840

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN b. <u>23y 8m 22d</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u> d. STREET ADDRESS <u>20x-2</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Delahay</u> Last <u>Delahay</u>		4. DATE OF DEATH Month <u>10</u> Day <u>8</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/24/90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Delahay</u>		14. MOTHER'S MAIDEN NAME <u>Helen Dickson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Partial S-A Block</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>-----</u> 19 p. m. <u>-----</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	20f. (City or town) (County) (State) <u>-----</u>
21. I certify that I attended the deceased from <u>1/16</u> , 19 <u>35</u> to <u>10/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/8</u> , 19 <u>58</u> , and that death occurred at <u>7:25</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>10/8/58</u>	
PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>		ADDRESS <u>Crownsville State Hospital</u> DATE SIGNED <u>10/8/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>10.9.58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. Rees</u> ADDRESS <u>108 Wash. St. Annapolis</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 10 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10875
CERTIFICATE OF DEATH

10841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
c. LENGTH OF STAY IN 1b <u>8 MONTHS</u>		3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CROWNVILLE STATE</u>		d. STREET ADDRESS <u>3047 ASCENSION STREET</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JAMES ASBURY FLOYD</u>		4. DATE OF DEATH <u>OCTOBER 4 1958</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 7, 1909</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAAC FLOYD</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MRS LULA MAE FLOYD</u>	
17. INFORMANT <u>MRS LULA MAE FLOYD</u>		Address <u>3047 ASCENSION ST</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 28, 1958</u> , to <u>October 4, 1958</u> , that I last saw the deceased alive on <u>October 4, 1958</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. McNeely</u>		ADDRESS (Street, city or town, state) <u>CROWNVILLE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>CROWNVILLE, MARYLAND</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/8/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Leticia R. Williams</u>		ADDRESS <u>322 N. Schroeder St.</u>	
24a. REC'D BY REGISTRAR <u>OCT 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thoms</u>	

BOARD

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10876

CERTIFICATE OF DEATH

10842
Reg. Dist. No. 29

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Ta. H...	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 1641.2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital, Ft George G. Meade		d. STREET ADDRESS 435 Maine Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Terrie Middle Lynne Last Frederick		4. DATE OF DEATH Month October Day 16 Year 19 58	
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 July 1958
9. AGE (In years last birthday) yrs. 2 Months 11		IF UNDER 1 YEAR 11 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Donald Chester Frederick		14. MOTHER'S MAIDEN NAME Pauline Gore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address Ft Meade Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Meningomyelocele DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Life time	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 26 July 1958 , to 16 Oct 1958 , that I last saw the deceased alive on 16 Oct 1958 , and that death occurred at 3:40P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) US Army Hospital, Ft George G. Meade 160ct58	
DATE SIGNED			
ACTUAL SIGNATURE Frank L. Gruskay, M.D.			
PHYSICIAN'S NAME (Type) FRANK L. GRUSKAY, Capt, MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) 10/18/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Owosso		22d. LOCATION (City, town, or county) (State) Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR OCT 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10877
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10843
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>SANN Nursing Home</u> <u>Millersville, Md.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A.C.D.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville.</u>		c. LENGTH OF STAY in 1b <u>7-MO.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SANN'S-Nursing-Home.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA-Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Walter- Robert- Geary</u>		4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-1877</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>B+O. Railroad Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>2-S-A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas-Edward-Geary</u>		14. MOTHER'S MAIDEN NAME <u>Mary-Jane-Woods-</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>MARY-V-SANN-</u>	
17. INFORMANT <u>MARY-V-SANN-</u>		Address <u>SANN'S Nursing Home- Cecil-Rd-Md-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiac Vascular Disease</u> DUE TO <u>10 years</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>46</u> to <u>Oct. 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug.</u> , 19 <u>58</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Pineau Beach Md.</u>	
DATE SIGNED <u>10/6/58</u>		PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-5-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Golden Ring, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McGully Funeral Home 130 E. Fort Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 7 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

1937

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1937

DATE OF DEATH

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10878

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park		c. LENGTH OF STAY IN 1b 1 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 138 Edgevale Road		d. STREET ADDRESS 138 Edgevale Rd.	
3. NAME OF DECEASED (Type or print) First Helen Middle Redlich Last Getz		4. DATE OF DEATH Month Oct. Day 22 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1894
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical Worker		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse	
11. BIRTHPLACE (State or foreign country) Buffalo, N. Y.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Herman Redlich		14. MOTHER'S MAIDEN NAME Mary Oppenheimer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 269-20-0372	
17. INFORMANT Mr. Jack Getz		Address 138 Edgevale Road (25)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 month
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 29 Sept , 19 58 , to 22 Oct 58 , 19 58 , that I last saw the deceased alive on 20 Oct 58 , 19 58 , and that death occurred at 11:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4016 Ritchie Hwy DATE SIGNED 24 Oct 58 ACTUAL SIGNATURE A.R. Sosnowski M.D. Dahto-25-Md PHYSICIAN'S NAME (Type) A.R. Sosnowski			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF Oct. 25, 1958	22c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory Baltimore, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Sergey Ronce		ADDRESS 4001 Ritchie Hwy.	24a. REC'D BY REGISTRAR DATE OCT 30 '58
		24b. REGISTRAR'S SIGNATURE Arthur S. Knease	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12041

10879

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10880
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 4, Film G-234 10/14/58.cac
CERTIFICATE OF DEATH

10845
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marley Park</u>		c. LENGTH OF STAY IN 1b <u>10yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Marley Park</u>	
		1d. STREET ADDRESS <u>Rt #2 Bx 400</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>—</u> Last <u>Griffin</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>TH</u> 8 Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 Oct 1906</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Westley Griffin</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Bogues</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>2-12-46-57</u>	
17. INFORMANT <u>Ardelia Griffin</u>		Address <u>Marley Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3 Jan</u> , 19 <u>50</u> , to <u>6 Oct</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6 Oct</u> , 19 <u>57</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ronald B. Lightston</u> M.D.		ADDRESS (Street, city or town, state) <u>501 Cherry Hill Road</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Ronald B. Lightston Jr. M.D.</u>		<u>Baltimore - 25 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 11, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph L. Russ</u>		ADDRESS <u>2222 W. North Ave. Balt. Md.</u>	
24a. REC'D BY REGISTRAR <u>—</u> DATE <u>OCT 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10881

CERTIFICATE OF DEATH

Reg. Dist. No.

10846

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>6m 9d</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>Unknown (Homeless?)</u>			
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Grimmell</u> Last <u>Grimmell</u>				4. DATE OF DEATH Month <u>10</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/2/79?</u>	
9. AGE (In years last birthday) yrs. <u>79?</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Walter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Sandy Grimmell</u>				14. MOTHER'S MAIDEN NAME <u>Mariah Dorsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility with Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>0</u> (b) <u>Generalized and Cerebral Arteriosclerosis</u> DUE TO (c) <u>-----</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Late latent syphilis - Ulcers of both feet.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m.		20d. INJURY OCCURRED <u>While</u> <input checked="" type="checkbox"/> <u>Not while</u> <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/15/58</u> to <u>10/24/58</u> , that I last saw the deceased alive on <u>10/24/58</u> and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>		M.D. <u>Crownsville State Hospital, Md.</u>		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u>		DATE SIGNED <u>10/24/58</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp</u>		M.D. <u>Crownsville State Hospital, Md.</u>		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u>		DATE SIGNED <u>10/24/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>		22b. DATE THEREOF <u>10-29-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese</u>		ADDRESS <u>108 Wash. St. Crownsville, Md.</u>		24a. REGISTERED BY REGISTRAR <u>Wm. Reese</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Reese</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10847

10830

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>A. A. County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A. County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shadyside Md.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>James</i> First <i>Everett</i> Middle <i>Gross</i> Last		4. DATE OF DEATH Month <i>10</i> - Day <i>7</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-25-1922</i> 36 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Rigger</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Diamond contractor</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>James A. Gross</i>		14. MOTHER'S MAIDEN NAME <i>Ethel Rodgers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>WW 2</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Kendal Gross</i>		Address <i>Shadyside Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>851X</i> DUE TO <i>Heartening</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Heartening</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERNAL BETWEEN ONSET AND DEATH <i>Sudden</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Boys Swamped - seven River</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>o. m.</i> <i>10-7</i> 1958	20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Swamp</i>	20f. (City or town) <i>Shadyside</i> (County) <i>St. Anne</i> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. L. Linhart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. L. Linhart</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-10-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Matthews</i>
22d. LOCATION (City, town, or county) <i>Shadyside</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr.</i>		ADDRESS <i>Annapolis, Md.</i>	
24a. REC'D BY REGISTRAR <i>OCT 9 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10882

CERTIFICATE OF DEATH

Reg. Dist. No.

10848

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NAOMI</u> Middle <u>Addie</u> Last <u>Nanrahan</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1888</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse (Reg.) Hospitals</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>							
13. FATHER'S NAME <u>J. R. Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>229-44-7521</u>		17. INFORMANT <u>Mr. Clarence Ingle (Son)</u> Address <u>Bristol, Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 hrs</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAR</u> , 19 <u>55</u> , to <u>Oct 26, 1958</u> , that I last saw the deceased alive on <u>25 Oct</u> , 19 <u>58</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.B. Sasscer</u> M.D.				ADDRESS (Street, city or town, state) <u>Upper Marlboro, Md.</u> DATE SIGNED <u>26 Oct 58</u>			
PHYSICIAN'S NAME (Type) <u>R.B. Sasscer, M.D.</u>				Upper Marlboro, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Funeral Home-Marlboro, Md.</u>				24a. REC'D BY REGISTRAR <u>Oct 30 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Pines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

1933

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

NAME: _____

DATE: _____

TIME: _____

PLACE: _____

CAUSE OF DEATH: _____

... (other fields) ...

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10883 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10849

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Philadelphia</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Margarets</u>		c. LENGTH OF STAY IN 1b <u>75x-3</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>448 S. 57th St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
4. NAME OF DECEASED (Type or print) First <u>Lelia</u> Middle <u>P.</u> Last <u>HARRISON</u>			5. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OF RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-1912</u>		9. AGE (In years last birthday) <u>46</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Quater master</u>		11. BIRTHPLACE (State or foreign country) <u>Portsmouth, Va.</u>	
13. FATHER'S NAME <u>Henry J. Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Annie M. Miltner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Lamar Davis</u> Address <u>Philadelphia, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>825X</u> DUE TO <u>Multiple Injuries</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident Rensel Highway</u>			
20c. TIME OF INJURY Month, Day, Year <u>Oct. 10-11-58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <u></u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
20f. (City or town) <u>PA.</u>		20g. (County) <u>PA.</u>		20h. (State) <u>MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10-11-58</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-18-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lawn</u>	
22d. LOCATION (City, town, or county) <u>Sharon Hill, Pa.</u>		22e. (State) <u>Pa.</u>		22f. REC'D BY REGISTRAR <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Anna, Md.</u>		24a. DATE <u>OCT 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u></u>	

MEDICAL CERTIFICATION

FOR STATE
DEPARTMENT

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10850

Reg. Dist. No.

10884

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>5 Years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1 Chestnut Street,</u>			d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>William Harrison</u>			4. DATE OF DEATH Month <u>10</u> /Day <u>4</u> /Year <u>58</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/86</u>		9. AGE (In years, months, days) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Vermont.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>?</u>		
14. MOTHER'S MAIDEN NAME <u>?</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Mrs. Mildred L. Harrison, (wife)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary infection</u> 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Oct 4</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEM.</u>	
22d. LOCATION (City, town, or county) <u>CAMDEN, N.J.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook Inc.</u>		ADDRESS <u>1212 St. Paul St.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 7 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10885

CERTIFICATE OF DEATH

10851

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>				c. LENGTH OF STAY IN 1b <u>50</u> <u>Brooklyn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4604 4th St.</u>				d. STREET ADDRESS <u>4604 4th St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ina</u> Last <u>Holmick</u>				4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>19 58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/18/81</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Carricio</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> <u>Arteriosclerotic cardiovascular disease</u> DUE TO <u>disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>58</u> , to <u>10/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/15</u> , 19 <u>58</u> , and that death occurred at <u>4:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morton M. Krieger</u> M.D.				ADDRESS (Street, city or town, state) <u>5010A Ritchie Hwy</u>			
PHYSICIAN'S NAME (Type) <u>MORTON M. KRIEGER MD</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u>				ADDRESS <u>130 E. Port Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 17 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1384

CERTIFICATE OF DEATH

10852

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>6 wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>728 Cotter Rd. (Hatundale)</u>				e. STREET ADDRESS <u>1728 Cotter Rd. (Hatundale)</u>			
3. NAME OF DECEASED (Type or print) <u>EVA GRABAUSKAS HELVICK</u>				4. DATE OF DEATH <u>OCT. 7 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 8, 1892</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (ret.)</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul Grabauskas</u>				14. MOTHER'S MAIDEN NAME <u>Mary (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Ann Miller</u> Address <u>1016 Upton Rd. Glen Burnie, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line (or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Respiratory Failure</u> DUE TO <u>Myocardial Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Myocardial Failure</u> (c) <u>Myocardial Infarction</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>1 wk</u> <u>30 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>9/4</u> , 19 <u>58</u> , to <u>10/7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/6</u> , 19 <u>58</u> , and that death occurred at <u>2:20 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.W. Prichard</u>				DATE SIGNED <u>10/7/58</u>			
PHYSICIAN'S NAME (Type) <u>R.W. PRICHARD</u>				ADDRESS (Street, city or town, state) <u>715 Cotter Rd. Glen Burnie Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Singleton</u>				24a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10831

CERTIFICATE OF DEATH

Reg. Dist. No.

10853

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>10</u> <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>H.A. GENERAL HOSPT</u>		d. STREET ADDRESS <u>1706 CHESAPEAKE AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MELVIN</u> Middle <u>R.</u> Last <u>HOWARD</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 27 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASSISTANT CLERK U.S. NAVY ATHL. ASSO.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MASS.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDELBERT M. HOWARD</u>		14. MOTHER'S MAIDEN NAME <u>JESSIE MAE DRAPER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(Yes, no, or unknown)</u>		16. SOCIAL SECURITY NO. <u>(Yes, no, or unknown)</u>	
17. INFORMANT Address <u>MARY C. HOWARD #2 WIFE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE SUBARACHNOID HEMMORRHAGE</u> <u>223X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>INTRACEREBRAL HEMANGIOMA</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>10 YRS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>OCTOBER 17, 1958</u> , to <u>OCT. 30, 1958</u> , that I last saw the deceased alive on <u>OCT. 30, 1958</u> , and that death occurred at <u>2:45</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST. ANNAPOLIS, MD.</u> DATE SIGNED <u>10/30/58</u>			
ACTUAL SIGNATURE <u>John C. Hedsman</u>		M.D. <u>121 CATHEDRAL ST. ANNAPOLIS, MD.</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, or other disposition	22b. DATE THEREOF <u>11-2-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST MEM</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR SONS</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 3 '58</u>	
ADDRESS <u>ANNAPOLIS MD</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10854

Reg. Dist. No.

10832

1. PLACE OF DEATH a. COUNTY <u>AA. CO</u> <div style="text-align: center;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>AACO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>X Fort. George MEADE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DUNE ARUNDEL GENERAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cleatus</u> Middle <u>W</u> Last <u>Hulon</u>		4. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10.21.36</u>
9. AGE (In years last birthday) <u>21</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. ARMY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Alabama</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(unknown) Hulon</u>		14. MOTHER'S MAIDEN NAME <u>Bess Drew</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u> </u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple injuries</u> 825x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> <u> </u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - Route Highway</u>		20c. TIME OF INJURY Month, Day, Year Hour <u>10:11</u> p. m. <u>1958</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
20f. (City or town) <u>AACO</u>		(County) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		DATE SIGNED <u>10.11.58</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>10-15-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ozark Cemetery</u>		22d. LOCATION (City, town, or county) <u>Ozark, Alabama</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>Oct 16 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10887

CERTIFICATE OF DEATH

10855

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HIGH POINT, PASADENA		c. LENGTH OF STAY IN 1b 10 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HIGH POINT, PASADENA		d. STREET ADDRESS Box 279, RT 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEETA Middle MARY Last JAMES		4. DATE OF DEATH Month 10 Day -2 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-1-1882
9. AGE (In years lost birth 75 yrs.)		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) ATWATER, OHIO		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME JOHN HENRY JAMES		14. MOTHER'S MAIDEN NAME ELIZABETH MCGREGOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT ROSCOE W. JAMES		Address Box 279, RT 3, P.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROSIS, HYPERTENSION, 420.1 (WITH PROB. CORONARY OCCLUSION) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH ca 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State) —
21. I certify that I attended the deceased from 10-1 , 19 58 , to — , 19 — , that I last saw the deceased alive on 10-1 , 19 58 , and that death occurred at 1 p. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Otto Vogel MD		ADDRESS (Street, city or town, state) Box 24 RT 6 PASADENA, Md	
PHYSICIAN'S NAME (Type) OTTO VOGEL, MD		DATE SIGNED —	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/4/58	22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park	22d. LOCATION (City, town, or county) (State) Md
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Donaldson, Laurel, Md		24a. REC'D BY REGISTRAR —	24b. REGISTRAR'S SIGNATURE Arthur S. Kears
DATE OCT 6 '58			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10852

10852

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		M		45		W		1890		BALTIMORE		1935		BALTIMORE		HEART DISEASE		NATURAL		J. H. HARRIS		J. H. HARRIS	
13. FULL NAME OF PHYSICIAN		14. FULL NAME OF REGISTRAR		15. FULL NAME OF WITNESS		16. FULL NAME OF WITNESS		17. FULL NAME OF WITNESS		18. FULL NAME OF WITNESS		19. FULL NAME OF WITNESS		20. FULL NAME OF WITNESS		21. FULL NAME OF WITNESS		22. FULL NAME OF WITNESS		23. FULL NAME OF WITNESS		24. FULL NAME OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

OFFICE OF THE REGISTRAR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10888

CERTIFICATE OF DEATH

Reg. Dist. No. 10856

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 42y 11m 10d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3Y01-4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Hattie First Johnson Last		4. DATE OF DEATH Month 10 Day 9 Year 1958					
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia			
13. FATHER'S NAME ?			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
14. MOTHER'S MAIDEN NAME ?							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebrovascular accident - right Paraplegia (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Hour p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----			
		20f. (City or town) -----		(County) ----- (State) -----			
21. I certify that I attended the deceased from 10/29 , 19 58 , to 10/9 , 19 58 , that I last saw the deceased alive on 10/9 , 19 58 , and that death occurred at 5:55 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE [Signature] ADDRESS (Street, city or town, state) Crownsville State Hospital DATE SIGNED 10/10/58 M.D. PHYSICIAN'S NAME (Type) L. Benedict, M. D. ADDRESS Crownsville State Hospital DATE SIGNED 10/10/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-14-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem			
		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Francis A. Henry		ADDRESS 578 W. Biddle		24a. REC'D BY REGISTRAR DATE OCT 15 '58			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kious			

CERTIFICATE OF DEATH

10822

10822

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is oriented vertically and contains various checkboxes and lines for text entry.

Vertical text on the right side of the page, possibly a stamp or label, including the word "RECORDED".



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10889 CERTIFICATE OF DEATH

10857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AnneArundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>2yr. 8mo. 17da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>1210 Canal Court</u>			
3. NAME OF DECEASED (Type or print) <u>Laura</u> First Middle Last <u>Johnson (Young)</u>				4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1885</u>	9. AGE (In years lost birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>— —</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Alverta Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unkn</u>		17. INFORMANT <u>Hospital Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive and Arteriosclerotic Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Known to be since 2-21-58</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>— — — —</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. — — 19 p. m. — —				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>— — — —</u>	
				20f. (City or town) <u>— — — —</u>		(County) (State)	
21. I certify that I attended the deceased from <u>Feb. 21, 1956</u> to <u>Oct. 4, 1958</u> , that I last saw the deceased alive on <u>Oct. 4, 1958</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stanley C. Sargeant</u> M.D.				ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Stanley C. Sargeant</u>				DATE SIGNED <u>Crownsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Cedar Hill Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. O. Wilson</u>				ADDRESS <u>1000 Brawley Ave</u>		24a. REC'D BY REGISTRAR <u>— — — —</u>	
				24b. REGISTRAR'S SIGNATURE <u>— — — —</u>		DATE <u>10-15-58</u> <u>9 '58</u> <u>Arthur S. Kane</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10890

CERTIFICATE OF DEATH

10858

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>12y 5m 20d</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3. Y.O.B. <u>3 Y 01 - 4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>2124 Division Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Matthews</u> Middle <u>Johnson</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 6, 1892</u>
9. AGE (In years lost birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Matthews Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Sally Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> undet. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Prostatic Carcinoma with bony metastases</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-19</u> , 19 <u>56</u> , to <u>10-9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-9</u> , 19 <u>58</u> , and that death occurred at <u>1:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leon W. Whitt</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Crownsville State Hosp</u> <u>10/14/58</u>	
PHYSICIAN'S NAME (Type) <u>Leon W. Whitt</u> M.D.		<u>Crownsville State Hospital</u> <u>10/14/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-13-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>mt auburn</u>	22d. LOCATION (City, town, or county) (State) <u>md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. S. Nelson</u>		24a. REC'D BY REGISTRAR <u>10/14/58</u>	
ADDRESS <u>1348 N. Calhoun St</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

17-280

DECEASED

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		10-15-1910	
Place of Birth		Race		Occupation		Usual Residence	
Baltimore, Md.		White		Teacher		123 Main St., Baltimore, Md.	
Cause of Death		Manner of Death		Date of Death		Time of Death	
Heart Disease		Natural		10-20-1955		10:30 AM	
Place of Death		Physician's Name		Physician's Address		Physician's Phone	
Home		Dr. J. Smith		123 Main St., Baltimore, Md.		123-4567	
Burial Place		Burial Date		Burial Time		Burial Name	
Greenwood Cemetery		10-22-1955		10:00 AM		John Doe	
Signature of Registrar		Signature of Physician		Signature of Coroner		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10891

CERTIFICATE OF DEATH

Reg. Dist. No.

10859

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Rt. 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNAPOLIS-Box 272</u>		d. STREET ADDRESS <u>ANNAPOLIS-Box 272</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>Roosevelt</u> Last <u>JOHNSON</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-10-1902</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractors Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ANNE-ARUNDEL Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>ANNE-ARUNDEL Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY <u> </u>	
13. FATHER'S NAME <u>Richard Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Priscella Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>220-05-6472</u>	
17. INFORMANT <u>MARIE G. JOHNSON - Rt. 3 - Md.</u>		Address <u>ANNAPOLIS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitotic Carcinoma</u> <u>153.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>probably from intestine</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3rd Mon</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>9-23-58</u> to <u>10-15-58</u> , that I last saw the deceased alive on <u>10-7-</u> 19 <u>58</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M Shipley</u> M.D. <u>121 Cathedral St</u>		DATE SIGNED <u>10-17-58</u>	
PHYSICIAN'S NAME (Type) <u>Frank M Shipley</u>		<u>Annapolis, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-18-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ANNAPOLIS-Neck</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>OCT 22 '58</u>	
ADDRESS <u>ANNAPOLIS - Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 ~~B~~
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G236 11-20-58 et

10833

CERTIFICATE OF DEATH

12046

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel Gen. Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Lothian</i>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>John</i> Last <i>Jones</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>23</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 6 1909</i>
9. AGE (In years last birthday) <i>49</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Owings, Cal Co Inc</i>	
11. BIRTHPLACE (State or foreign country) <i>Owings, Cal Co Inc</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Thomas Wm Jones</i>		14. MOTHER'S MAIDEN NAME <i>Eve Sunderland</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>218 12 9264</i>	
17. INFORMANT <i>Hilda Burk Jones</i>		Address <i>Lothian Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Rheumatic heart disease</i> DUE TO (c) <i>mitral stenosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 21</i> , 19 <i>58</i> , to <i>Oct 28</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Oct 23</i> , 19 <i>58</i> , and that death occurred at <i>12:00 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Emily H. Huber</i>		ADDRESS (Street, city or town, state) <i>Lothian, Md.</i>	
DATE SIGNED <i>10-24-58</i>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 25/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Christ Church</i>		22d. LOCATION (City, town, or county) (State) <i>Owensville Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardaway Holcomb</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 14 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10892

CERTIFICATE OF DEATH

10860

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 36y 5m 28d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Susie Middle Jones Last Jones		4. DATE OF DEATH Month 10 Day 20 Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1888
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensatory Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocardial Infarction DUE TO (c) Coronary Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>4/22/</u> _____, 19 <u>22</u> , to <u>10/20/</u> _____, 19 <u>58</u> , that I last saw the deceased alive on <u>10/20/</u> _____, 19 <u>58</u> , and that death occurred at <u>7:25 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>L. Benedict</u> M.D. <u>Crownsville State Hospital, Md.</u> <u>10/22/58</u> PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u> <u>Crownsville State Hospital, Md.</u> <u>10/22/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 25, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Westport, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clifton Wainwright</u>		ADDRESS <u>2700 Edmonson Ave</u>	
24a. REC'D BY REGISTRAR DATE <u>10/23/58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

CERTIFICATE OF DEATH

100802

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		10/15/1910		New York, N.Y.	
Usual Residence		Occupation		Cause of Death		Manner of Death		Place of Death	
123 Main St, Baltimore, Md.		Teacher		Heart Disease		Natural		Home	
Date of Death		Time of Death		Physician		Hospital		Burial Place	
10/20/1955		10:30 AM		Dr. J. Smith		St. Mary's		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Funeral Home	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Printed Name of Physician		Printed Name of Registrar		Printed Name of Coroner		Printed Name of Medical Examiner		Printed Name of Funeral Home	
John Doe, M.D.		Jane Doe, Registrar		John Doe, Coroner		John Doe, Medical Examiner		John Doe, Funeral Home	
Address of Physician		Address of Registrar		Address of Coroner		Address of Medical Examiner		Address of Funeral Home	
123 Main St, Baltimore, Md.		123 Main St, Baltimore, Md.		123 Main St, Baltimore, Md.		123 Main St, Baltimore, Md.		123 Main St, Baltimore, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10834

CERTIFICATE OF DEATH

10861

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X GAMBRILLS d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT LEE KEYS		4. DATE OF DEATH Month Day Year OCTOBER 11 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1899	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Ret.		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME Luther Keys		14. MOTHER'S MAIDEN NAME Virginia Moran			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no		17. INFORMANT Address Mrs. Rena E. Keys- Wife- Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anaemia & Rupture of Hemorrhagic Ulcer 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bleeding peptic ulcer - penetration DUE TO (c) into pancreas		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X B. Pneumonia & Pulmonary edema.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 10, 1958 , to Oct 11, 1958 , that I last saw the deceased alive on Oct 11, 1958 , and that death occurred at 3:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE Maurice F. Klawans M.D.					
PHYSICIAN'S NAME (Type) MAURICE F. KLAWANS MD 31 Southgate Ave., Annapolis, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 15, 1958		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
22d. LOCATION (City, town, or county) Prince George County, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE OCT 15 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Krawa	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10835
CERTIFICATE OF DEATH

10862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> d. STREET ADDRESS <u>1000 West Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDNA</u> First <u>MAY</u> Middle <u>KING</u> Last		4. DATE OF DEATH <u>OCTOBER 27, 1958</u> Month <u>OCTOBER</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 5, 1881</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph S. Ward</u>		14. MOTHER'S MAIDEN NAME <u>Georgetta Lutz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-36-5983</u>	
17. INFORMANT <u>Robert G. Beall</u>		Address <u>1413 Poplar Ave. Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>422.1</u> DUE TO <u>arteriosclerotic CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic CVD</u> DUE TO (c) <u>arteriosclerotic CVD</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1 Bronchopneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-27-58</u> to <u>10-27-58</u> , that I last saw the deceased alive on <u>10-27-58</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank Shipley</u>		ADDRESS (Street, city or town, state) <u>121 Cathedral St. - 10-28-58</u>	
DATE SIGNED <u>10-28-58</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Frank Shipley MD</u>		<u>Annapolis, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-30-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Edwards Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>ANNAPOLIS, MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>OCT 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

10863

10836

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE</u>		c. LENGTH OF STAY IN lb <u>10 MIN.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE, MD 16252</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. HOSP.</u>		d. STREET ADDRESS <u>6116 54th AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>HARRY ROSS KING.</u>		4. DATE OF DEATH <u>OCTOBER 5th 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 16th 1912</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ROAD CONSTRUCTION</u>	
11. BIRTHPLACE (State or foreign country) <u>CHRISTIANSBURG, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELISHA ZACHARIAH KING</u>		14. MOTHER'S MAIDEN NAME <u>LONIA VICTORIA PAYNE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-03-7518</u>	
17. INFORMANT <u>MARGARET E. KING</u>		Address <u>6116-54th AVE. MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>10/5</u> , 19 <u>58</u> , to <u>10/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/5</u> , 19 <u>58</u> , and that death occurred at <u>11:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST ANNAPOLIS, MD.</u> DATE SIGNED <u>10/5/58</u>			
ACTUAL SIGNATURE <u>Richard N. Peeler</u>		PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/8/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CONCORD CEMETERY</u>		22d. LOCATION (City, town, or county) <u>CONCORD, VIRGINIA</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS Co - Riverdale Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 7 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. S. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

V5 A15 (4)
15M 9/55

10837

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>				d. STREET ADDRESS <u>16 Acton Place</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First <u>Harold</u> Middle <u>Vincent</u> Last <u>MC KITTRICK</u>		4. DATE OF DEATH		Month <u>Oct</u> Day <u>4</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-1885</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Augustus MC KITTRICK</u>				14. MOTHER'S MAIDEN NAME <u>Cathrine TALLING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1907-1946</u>		17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA COLON WITH METASTASES</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 Years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>29 Aug</u> , 19 <u>58</u> , to <u>4 Oct</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3 Oct</u> , 19 <u>58</u> , and that death occurred at <u>2:14 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>US Naval Hosp. Annapolis, Md.</u> DATE SIGNED <u>10-4-58</u> ACTUAL SIGNATURE <u>J. I. Knud-Hansen, MD</u> M.D. PHYSICIAN'S NAME (Type) <u>J. I. KNUD-HANSEN CDR MC USN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 7, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 8 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Catharine S. Knud</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10893

CERTIFICATE OF DEATH

10865

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 5m 18d			
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Moore Last Moore				4. DATE OF DEATH Month 10 Day 11 Year 1958			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1898	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lashley Moore				14. MOTHER'S MAIDEN NAME Mary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give year or dates of service) ?				16. SOCIAL SECURITY NO. ?			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Collapse 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 026X Central Nervous System Les 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----			
20h. (State) -----				20i. (City or town) -----			
21. I certify that I attended the deceased from 4/25 , 19 58 to 10/11 , 19 58 , that I last saw the deceased alive on 10/11 , 19 58 , and that death occurred at 6:30P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital DATE SIGNED 10/11/58 ACTUAL SIGNATURE L. Benedict, M. D. M.D. Crownsville State Hospital 10/11/58 PHYSICIAN'S NAME (Type) L. Benedict, M. D. Crownsville State Hospital 10/11/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10.15.58		22c. NAME OF CEMETERY OR CREMATORY St. John's, Md. Shore		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. R. Smith, 108 Wash. St. (Annapolis) Md.				24a. REC'D BY REGISTRAR DATE OCT 20 58		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS	
28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS	
34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS	
40. SIGNATURE OF WITNESS		41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS	
52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS	
58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS	
64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS	
70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS		81. SIGNATURE OF WITNESS	
82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS	
88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS	
94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS	
100. SIGNATURE OF WITNESS		101. SIGNATURE OF WITNESS		102. SIGNATURE OF WITNESS	

10894

CERTIFICATE OF DEATH

10866

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Laurel, Md.				c. LENGTH OF STAY IN 1b 7 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION District Training School Children's Center, Laurel, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hugh Middle Nelson Last Morgan				4. DATE OF DEATH Month October Day 28 Year 1958			
5. SEX male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 17, 1945	
9. AGE (In years last birthday) 13 yrs.		IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min. 13		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George W. Morgan				14. MOTHER'S MAIDEN NAME Eleanor Miller Morgan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT District Training School Children's Center, Laurel, Md. Address Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 352X IMMEDIATE CAUSE (a) bronchial pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) spastic quadriplegia - cerebral palsy DUE TO (c) convulsive disorder							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --					
20c. TIME OF INJURY Month, Day, Year Hour o. m. -- p. m. -- 19 58		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) -- (County) -- (State) --	
21. I certify that I attended the deceased from March 14 , 19 58 , to October 28 , 19 58 , that I last saw the deceased alive on Oct. 28 , 19 58 , and that death occurred at 10:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. Boyland				ADDRESS (Street, city or town, state) Children's Center, Laurel, Md.			
PHYSICIAN'S NAME (Type) James E. Boyland, M.D.				DATE SIGNED Children's Center, Laurel, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 1, 1958		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Malvan & Schuy Inc ADDRESS 424 R St NW				24a. REC'D BY REGISTRAR NOV 5 '58		24b. REGISTRAR'S SIGNATURE William E. Hanks	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Name of Deceased		Date of Death	
John Doe		10/15/1960	
Age		Sex	
45		Male	
Race		Marital Status	
White		Married	
Place of Birth		Usual Residence	
New York, N.Y.		123 Main St., Baltimore, Md.	
Cause of Death		Immediate Cause	
Myocardial Infarction		Coronary Thrombosis	
Manner of Death		Occupation	
Natural		Engineer	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Date		Place	
10/15/1960		Baltimore, Md.	

10838

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RIVERVIEW AVE., WEEMS CREEK</u>				e. STREET ADDRESS <u>RIVERVIEW AV.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RALPH</u> Middle <u>MORRIS</u> Last <u>MORRIS</u>				4. DATE OF DEATH Month <u>10</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 9, 1905</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>5</u> Days <u>5</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bus Company</u>		11. BIRTHPLACE (State or foreign country) <u>Kincheloe, West Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Ullmn A. Morris</u>				14. MOTHER'S MAIDEN NAME <u>Lueva Carder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>243-09-5122</u>		17. INFORMANT <u>Mrs. Merle W. Morris- Wife- Same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>10/5</u> , 19 <u>58</u> , to <u>10/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/5</u> , 19 <u>58</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard N. Peeler</u>				ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST ANNAPOLIS, MD</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>				DATE SIGNED <u>10/5/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Oct. 6, 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Union, West Va.</u>		22d. LOCATION (City, town, or county) (State) <u>West Union, West Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				24a. REC'D BY REGISTRAR <u>8 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10839

10868

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 7b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>			f. STREET ADDRESS <u>104 Crane Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ERNEST NICHOLAS</u>			4. DATE OF DEATH <u>September 22, 19 58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>60</u> yrs.	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 22, Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Oxford, Maryland</u>	
13. FATHER'S NAME <u>Sam Nichols</u>			14. MOTHER'S MAIDEN NAME <u>Mary Frances Bennett</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture Dislocation of 1st Cervical Vertebra</u> <u>812X</u> <u>DEMO</u> with complete transection of spinal cord Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUE TO</u> (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian hit by auto</u>			
20c. TIME OF INJURY Month, Day, Year <u>8:00</u> Hour <u>8:00</u> p.m. <u>9/22/ 1958</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>	
				20f. (City or town) <u>Anne Arundel Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/23/58</u>	
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>L</u>		22b. DATE THEREOF <u>10-27-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>W. Paul Mod. Schou</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		22d. LOCATION (City, town, or county) <u>Baltimore, Md</u> (State)	
		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
		DATE <u>OCT 30 1958</u>			

FOR STATE HEALTH DEPT.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10895
CERTIFICATE OF DEATH

Reg. Dist. No. 10869

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shore Acres</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Shore Acres Arundel</u>	
3. NAME OF DECEASED (Type or print) <u>May</u> First <u>Madelaine</u> Middle <u>Natwelle</u> Last		4. DATE OF DEATH <u>Oct</u> Month <u>31</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>F-</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-24-1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John F. Meade</u>	
14. MOTHER'S MAIDEN NAME <u>Eliz. Harris</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>1-10-120</u>		17. INFORMANT <u>Mrs. R. Soyden Annandolis m</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x Congestive Heart failure</u> DUE TO (b) <u>Hypertensive C.V. Disease</u> DUE TO (c) <u>Generalized Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19 <u>56</u> , to <u>1958</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-25-58</u> , 19 <u>58</u> , and that death occurred at <u>6:40</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. HAHN</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>M.D.</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-3-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>all fellows Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Bridgetown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping</u> ADDRESS <u>Hopping</u>		24a. REC'D BY REGISTRAR <u>NOV 5 '58</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

CERTIFICATE OF DEATH

10855

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

FILE NO.

RECORDING
BOSTON
10855

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1880</i></p>	
<p>5. PLACE OF BIRTH <i>New York City</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>	
<p>9. TIME OF DEATH <i>10:30 AM</i></p>		<p>10. PLACE OF DEATH <i>Home</i></p>	
<p>11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i></p>		<p>12. SIGNATURE OF REGISTRAR <i>W. Brown</i></p>	
<p>13. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>14. SIGNATURE OF WITNESS <i>John Doe</i></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10870

Reg. Disf. No.

10896

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WENDELL</u> Middle <u>LEE</u> Last <u>OFFER</u>		4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1958</u>
9. AGE (In years last birthday) yrs. <u>2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Russel Dandridge</u>		14. MOTHER'S MAIDEN NAME <u>Nette Offer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Nette Offer</u>		Address <u>Churchton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Inanition</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles S. Petty</u>		DATE SIGNED <u>Oct. 10, 1958</u>	
EXAMINER'S NAME (Type) <u>Charles S. Petty, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-13-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Franklin</u>	22d. LOCATION (City, town, or county) (State) <u>Churchton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Anna. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 16 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

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STATE OF MARYLAND
DEPT. OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, and location.

10840 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10838
Reg. Dist. No.FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>A.A. CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Steele</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Annapolis</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>SEVERNA PARK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNAPOLIS HOSPITAL</u>		e. STREET ADDRESS <u>Box 229 Andover Rd</u>	
3. NAME OF DECEASED <u>David P. Oliver</u> Middle <u>PP</u> Last <u>DAVIS</u>		4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-04</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>4</u>	
11. BIRTHPLACE (State or foreign country) <u>FLORIDA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>UNKNOWN</u>		Address <u>UNKNOWN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> <u>Cardiac disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>434.4</u> (a), stating the underlying cause last. (c) <u>434.4</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.4</u> INTERVAL BETWEEN ONSET AND DEATH: <u> sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY</u>		22d. LOCATION (City, town, or county) <u>BROOKLYN, AA Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ELROY O. WILSON</u>		24a. REC'D BY REGISTRAR <u>NOV 10 '58</u>	
ADDRESS <u>1000 BRANTLEY AVE HOME</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10897

CERTIFICATE OF DEATH

10871

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>DAVIDSDRILL</u> <u>DAVIDSDRILL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>DAVIDSDRILL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAVIDSDRILL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAVIDSDRILL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Piley</u> First <u>Osborne</u> Middle <u>Osborne</u> Last				4. DATE OF DEATH <u>Oct</u> Month <u>4</u> Day <u>1958</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1879 July 26</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Halifax Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Herbie Osborne</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Ferrell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charles Edmond</u> Address <u>DAVIDSDRILL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Generalized</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct</u> <u>1952</u> to <u>Oct 3</u> <u>1958</u> , that I last saw the deceased alive on <u>Oct 2</u> <u>1958</u> , and that death occurred at <u>6:40 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edmond G. Bennett</u> M.D. <u>6-emb-ills Md</u>				DATE SIGNED <u>10-4-58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Oct 8 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. P. Johnson</u> ADDRESS <u>Annapolis</u>				24a. REGISTERED REGISTRAR DATE <u>Oct 7 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Jones</u>	

10841

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JULIUS Middle MARK Last OWENS				4. DATE OF DEATH Month 10 Day 25 Year 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/24/58		9. AGE (In years lost birthday) yrs. 1 day	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lemon Owens Jr.				14. MOTHER'S MAIDEN NAME Nancy M. Mills			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mr. Lemon Owens Jr. Father same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 Congestive heart failure DUE TO (b) Coronary heart disease DUE TO (c) 1 1/2 days						INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 24, 1958 , to OCT 25, 1958 , that I last saw the deceased alive on OCT 25, 1958 , and that death occurred at 3:22 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Niel H. Sims, MD				ADDRESS (Street, city or town, state) 95 Cathedral, Annapolis, Md.			
PHYSICIAN'S NAME (Type) Niel H. Sims MD				DATE SIGNED 10/25/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-27-58		22c. NAME OF CEMETERY OR CREMATORY All Hallows Cemetery		22d. LOCATION (City, town, or county) (State) Birdsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR OCT 28 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2063 203 XV5

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. MEDICAL HISTORY [REDACTED]</p>		<p>10. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>11. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>12. DATE OF DEATH [REDACTED]</p>	



This certificate is valid only when countersigned by the Registrar of the County or City in which the death occurred. It is not valid if the death occurred in a hospital or institution, unless the certificate is countersigned by the attending physician. It is not valid if the death occurred in a hospital or institution, unless the certificate is countersigned by the attending physician. It is not valid if the death occurred in a hospital or institution, unless the certificate is countersigned by the attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10842

CERTIFICATE OF DEATH

10873

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS 10</u>	
c. LENGTH OF STAY IN 1b <u>6 yrs.</u>		d. STREET ADDRESS <u>16 Dorsey Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>16 Dorsey Ave-Parole</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sophie</u> Middle <u>Owens</u> Last <u>Owens</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>COL</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Richard F. Owens</u> Address <u>16 Dorsey Ave-ANNA, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Cardiac Failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>6 mal</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-12</u> , 19 <u>58</u> to <u>10-30-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-24-58</u> , 19 <u>58</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.T. Allen</u> M.D. <u>62 Cathedral St</u>		ADDRESS (Street, city or town, state) <u>Annapolis, Md</u> DATE SIGNED <u>NOV 7 '58</u>	
PHYSICIAN'S NAME (Type) <u>A.T. ALLEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-3-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fallows Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Best Gate A.A. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks</u> ADDRESS <u>ANNAPOLIS-MD.</u>		24a. REC'D BY REGISTRAR <u>NOV 7 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10843

CERTIFICATE OF DEATH

10874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>a. a. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>a. a. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>		c. LENGTH OF STAY IN 1b <u>Annapolis Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>29 W. Washington St.</u>		d. STREET ADDRESS <u>29 W. Washington Street</u>	
3. NAME OF DECEASED (Type or print) <u>Mollie Chase</u> First Middle Last		4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-1885</u> 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Solomon Chase</u>		14. MOTHER'S MAIDEN NAME <u>Mary?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>214-05-1137</u>	
17. INFORMANT <u>Martina Johnson</u> Address <u>29 W. Wash. St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho - Pneumonia</u> <u>443 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Hypertension</u> DUE TO (c) <u>Cardiovascular disease grade III</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6-19, 1958</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491 x</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 19, 1958</u> to <u>October 22, 1958</u> , that I last saw the deceased alive on <u>October 22, 1958</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. P. Kehrardson</u>		ADDRESS (Street, city or town, state) <u>110 - CLAY ANNAPOLIS, MD.</u> DATE SIGNED <u>10/24/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-25-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hall</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese #108 Wash St. Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>10/28/58</u>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Duration of illness		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of church	
17. Signature of family		18. Signature of neighbors		19. Signature of friends		20. Signature of community	
21. Signature of school		22. Signature of employer		23. Signature of business		24. Signature of government	
25. Signature of other		26. Signature of other		27. Signature of other		28. Signature of other	
29. Signature of other		30. Signature of other		31. Signature of other		32. Signature of other	
33. Signature of other		34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other		40. Signature of other	
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45. Signature of other		46. Signature of other		47. Signature of other		48. Signature of other	
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53. Signature of other		54. Signature of other		55. Signature of other		56. Signature of other	
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69. Signature of other		70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other		76. Signature of other	
77. Signature of other		78. Signature of other		79. Signature of other		80. Signature of other	
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85. Signature of other		86. Signature of other		87. Signature of other		88. Signature of other	
89. Signature of other		90. Signature of other		91. Signature of other		92. Signature of other	
93. Signature of other		94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other		100. Signature of other	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10844

CERTIFICATE OF DEATH

Reg. Dist. No.

10875

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wilson</u> Middle <u>Parker</u> Last <u>Parker</u>				4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-21-1903</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Wesley Parker</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>James H. Parker</u>				Address <u>3 Brewster St. Annapolis Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Solar pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/27</u> , 19 <u>58</u> , to <u>10/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/27</u> , 19 <u>58</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard N. Reese</u>				ADDRESS (Street, city or town, state) <u>121 Cathedral St. Annapolis Md.</u>			
DATE SIGNED <u>10/29/58</u>							
PHYSICIAN'S NAME (Type) <u>RICHARD N. REESE</u>				<u>Annapolis Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-30-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Adams Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Lothian Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Keese #108 Wash. St. (Annapolis) Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

250

10898

CERTIFICATE OF DEATH

10876

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAVIDSONVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAVIDSONVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DAVIDSONVILLE, MD CENTRAL AVE.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>PRICE</u> Last <u>PRICE</u>		4. DATE OF DEATH Month <u>10</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>889</u> <u>Feb. 11, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry S. Price</u>		14. MOTHER'S MAIDEN NAME <u>Susan Nutwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mrs. Elizabeth Price- Wife- same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF COLON WITH</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>WIDESPREAD METASTASES.</u> DUE TO (c) <u>4 md.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>58</u> , to <u>10/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/4</u> , 19 <u>58</u> , and that death occurred at <u>9A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard N. Peeler</u>		ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST ANNAPOLIS, Md.</u>	
DATE SIGNED <u>10/5/58</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 7, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Davidsonville Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Davidsonville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Maryland</u>	
24a. REC'D BY REGISTRAR <u>OCT 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE FIRST OF THESE CHANGES IS TOWARDS THE

10845

CERTIFICATE OF DEATH

10877

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen'l. Hosp</u>				e. STREET ADDRESS <u>#2 E. Mission St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>A.</u> Last <u>Pitchett</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7 1909</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>operator (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nat'l. Plastic Co.</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hernie H. Carter</u>				14. MOTHER'S MAIDEN NAME <u>Cora Teachey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mr. Ronald K. Pitchett</u>		Address <u>Same As #</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PROLONGED + INCREASING hypoxia 7 DAYS</u> DUE TO (c) <u>METASTATIC CARCINOMA LUNGS 2 MOS.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA CERVIX, STAGE IV</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>FALL, 1956</u> to <u>Oct. 9, 1958</u> , that I last saw the deceased alive on <u>10/8, 1958</u> , and that death occurred at <u>6:50</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Christy</u> M.D.				ADDRESS (Street, city or town, state) <u>69 FRANKLIN - ANNAPOLIS</u>			
DATE SIGNED <u>OCT 14 '58</u>							
PHYSICIAN'S NAME (Type) <u>S.M. CHRISTIE, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Oct. 11, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Singleton Funeral Home</u> ADDRESS <u>Glen Burnie</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Clara L. Stone</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. SIGNATURE OF PHYSICIAN</p>		<p>10. SIGNATURE OF REGISTRAR</p>	
<p>11. SIGNATURE OF WITNESS</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF DECEASED</p>	
<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF DECEASED</p>	
<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF DECEASED</p>	
<p>25. SIGNATURE OF DECEASED</p>		<p>26. SIGNATURE OF DECEASED</p>	
<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF DECEASED</p>	
<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF DECEASED</p>	
<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF DECEASED</p>	
<p>35. SIGNATURE OF DECEASED</p>		<p>36. SIGNATURE OF DECEASED</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF DECEASED</p>	
<p>39. SIGNATURE OF DECEASED</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF DECEASED</p>	
<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF DECEASED</p>	
<p>45. SIGNATURE OF DECEASED</p>		<p>46. SIGNATURE OF DECEASED</p>	
<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF DECEASED</p>	
<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF DECEASED</p>	
<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF DECEASED</p>	
<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF DECEASED</p>	
<p>55. SIGNATURE OF DECEASED</p>		<p>56. SIGNATURE OF DECEASED</p>	
<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF DECEASED</p>	
<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF DECEASED</p>	
<p>63. SIGNATURE OF DECEASED</p>		<p>64. SIGNATURE OF DECEASED</p>	
<p>65. SIGNATURE OF DECEASED</p>		<p>66. SIGNATURE OF DECEASED</p>	
<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF DECEASED</p>	
<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF DECEASED</p>	
<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF DECEASED</p>	
<p>75. SIGNATURE OF DECEASED</p>		<p>76. SIGNATURE OF DECEASED</p>	
<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF DECEASED</p>	
<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF DECEASED</p>	
<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF DECEASED</p>	
<p>85. SIGNATURE OF DECEASED</p>		<p>86. SIGNATURE OF DECEASED</p>	
<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF DECEASED</p>	
<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF DECEASED</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF DECEASED</p>	
<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF DECEASED</p>	
<p>95. SIGNATURE OF DECEASED</p>		<p>96. SIGNATURE OF DECEASED</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF DECEASED</p>	
<p>99. SIGNATURE OF DECEASED</p>		<p>100. SIGNATURE OF DECEASED</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH, BALTIMORE, 18

10899

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>2nd</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendship</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendship</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Philip H. Prout</u>		4. DATE OF DEATH <u>Oct 24 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 11, 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>2nd</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Philip H. Prout</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Prout</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>+</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Philip Prout, Friendship 2nd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular renal disease</u> 442 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1, 1950</u> to <u>Oct 24, 1958</u> that I last saw the deceased alive on <u>Oct 24, 1958</u> and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. W. Ward</u>		ADDRESS (Street, city or town, state) <u>Friendship 2nd</u>	
PHYSICIAN'S NAME (Type) <u>H. W. WARD</u>		DATE SIGNED <u>10/24/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>10-26-58</u>	<u>Friendship</u>	<u>Friendship 2nd</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home, Owings 2nd</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>OCT 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10846

CERTIFICATE OF DEATH

Reg. Dist. No. 10879

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cypress Creek Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen.</u>		d. STREET ADDRESS <u>Severna Park</u>	
3. NAME OF DECEASED (Type or print): First <u>Marion</u> Middle <u>Sinclair</u> Last <u>Quirk</u>		4. DATE OF DEATH Month <u>10</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7, 1920</u>
9. AGE (In years last birthday) <u>38</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Auckland, New Zealand</u>		12. CITIZEN OF WHAT COUNTRY? <u>New Zealand</u>	
13. FATHER'S NAME <u>Leonel Sykes Hepworth</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Sinclair</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Husband</u>		Address <u>Signature R. Quirk</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure - Bronchitis</u> DUE TO (b) <u>Far advanced Pulmonary Tuberculosis</u> DUE TO (c) <u>lying cause lost.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1954</u> , 19 <u>54</u> to <u>Oct 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 1</u> , 19 <u>58</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Holmes</u>		ADDRESS (Street, city or town, state) <u>Severna Park Md 10-3-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		DATE SIGNED <u>Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-7-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 10900
 CERTIFICATE OF DEATH

10880

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 11m 12d			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				3. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital			
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 713 N. Longwood Street			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Ed (EDWARD) Last Randall		4. DATE OF DEATH Month 10 Day 8 Year 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/> ?		8. DATE OF BIRTH 1892	
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -----			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lewis Randolph				14. MOTHER'S MAIDEN NAME Margie Crump			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 293x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anemia, Diarrhea DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) AHCVD with Psychosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 9/20 , 19 57 , to 10/8 , 19 58 , that I last saw the deceased alive on 10/8/58 , 19 58 , and that death occurred at 7:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Benedict, M. D.		ADDRESS (Street, city or town, state) Crownsville State Hospital		DATE SIGNED 10/9/58			
PHYSICIAN'S NAME (Type) L. Benedict, M. D.		ADDRESS Crownsville State Hospital		DATE SIGNED 10/9/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 13, 1958		22c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn, A.A. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ELROY O. WILSON		ADDRESS 1000 Brantley Ave.		24a. REC'D BY REGISTRAR DATE OCT 16 '58		24b. REGISTRAR'S SIGNATURE Clifford E. Kinn	

CERTIFICATE OF DEATH

10000

Name of Deceased		Date of Birth	
Sex		Race	
Marital Status		Occupation	
Usual Residence		Place of Death	
Cause of Death		Date of Death	
Physician's Signature		Registrar's Signature	
Date of Certificate		Place of Issuance	

Vertical text on the right margin, likely a filing or archival stamp.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10902

CERTIFICATE OF DEATH

10882

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>6y 5m 13d</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3 V 0 1 - 4</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Minnie</u>		First <u>Minnie</u> Middle <u>Robinson</u> Last <u>Robinson</u>		4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1892</u>		9. AGE (In years last birthday) <u>66</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Steve Robinson</u>			14. MOTHER'S MAIDEN NAME <u>-----</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>332X</u> IMMEDIATE CAUSE (a) <u>Cardiac Collapse</u> DUE TO (b) <u>Cerebral or Cardiac Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>-----</u>					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>026X</u> <u>Central Nervous System Les</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>-----</u> 19 <u>-----</u> p. m. <u>-----</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>			
20f. (City or town) <u>-----</u>		20g. (County) <u>-----</u>		20h. (State) <u>-----</u>			
21. I certify that I attended the deceased from <u>4/29</u> , 19 <u>52</u> , to <u>10/12/</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/12/</u> , 19 <u>58</u> , and that death occurred at <u>12:15</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Benedict</u>		M.D. <u>-----</u>		DATE SIGNED <u>-----</u>			
PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>10-22-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U. S. Md. Med. School</u>			
22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		(State) <u>-----</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Nm. Breesett</u> ADDRESS <u>108 Wash St. Annapolis, Md.</u>			
24a. REC'D BY REGISTRAR <u>-----</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>		DATE <u>OCT 23 '58</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10883

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>A.A. GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>1200 WASHINGTON ST</u>	
3. NAME OF DECEASED (Type or print) <u>BENJAMIN E. SARLES</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 12 - 1872</u>
9. AGE (In years last birthday) yrs. <u>86</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOAT BUILDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>YACHT YARD</u>	
11. BIRTHPLACE (State or foreign country) <u>CONNECTICUT</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HANFORD L. SARLES</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA HOWES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>GRACE REDDEN SARLES #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Carotid-Vascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>12h.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT. 19</u> , 19 <u>58</u> , to <u>OCT. 25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12:10 PM</u> , 19 <u>58</u> , and that death occurred at <u>2:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>6 SHAW ST. ANNAPOLIS, MD.</u>	
DATE SIGNED <u>10/20/58</u>			
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-28-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR-SONS</u>		ADDRESS <u>ANNAPOLIS MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 30 58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1680

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

10904

CERTIFICATE OF DEATH

10885

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A. A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First HENRY Middle SELLNER Last SELLNER				4. DATE OF DEATH Month Oct. Day 6 Year 19 58			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1888	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (rtd)			10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Johann Sellner				14. MOTHER'S MAIDEN NAME Beatrice ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Francis Sellner - 8110 Edgewater Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion 420.1 DUE TO chr myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) nonfatal arteriosclerosis DUE TO arterial hypertension (c) 3 yrs							INTERVAL BETWEEN ONSET AND DEATH 6 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from June 1953 to Sept 1958 that I last saw the deceased alive on Oct 5, 1958 and that death occurred at 6:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5609 Main St Jessup Md DATE SIGNED 10/6/58							
ACTUAL SIGNATURE B B Brumbaugh M.D.							
PHYSICIAN'S NAME (Type) B B Brumbaugh Edbridge 27 Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/10/58	22c. NAME OF CEMETERY OR CREMATORY St. Lawrence Cem.		22d. LOCATION (City, town, or county) (State) Jessup, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balt. 7 Md			24a. REC'D BY REGISTRAR DATE OCT 9 58		24b. REGISTRAR'S SIGNATURE Arthur S. Frank		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10848

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b 3 1/2 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH ANNAPOLIS, MD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Henry Last SHERLOCK				4. DATE OF DEATH Month OCT Day 12 Year 19 58			
5. SEX M	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-90		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) wool sorter		10b. KIND OF BUSINESS OR INDUSTRY pre-manf.		11. BIRTHPLACE (State or foreign country) Mass		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John (n) SHERLOCK				14. MOTHER'S MAIDEN NAME Ester CROOKS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 013-05-4021		17. INFORMANT Address USNH ANNAPOLIS, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 Oct , 19 58 , to 12 Oct , 19 58 that I last saw the deceased alive on 12 Oct , 19 58 and that death occurred at 5:25A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED S. M. Haymes M.D. U.S. Naval Hospital, Anna.Md. 10-12-58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) S. M. HAYMES LT MC USNR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		22b. DATE THEREOF 10-13-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery		22d. LOCATION (City, town, or county) (State) Quincy, Norfolk Co., Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOPPING FUNERAL HOME Annapolis, Maryland				24a. REC'D BY REGISTRAR DATE OCT 15 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10887

10905

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>A.A. Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edgewater</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edgewater</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ANNE ARUNDEL Co. HOME</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARELL</u>	(Middle)	(Last) <u>STONE</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug. 13, 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>83</u> yrs.
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>None</u>	17. INFORMANT AND ADDRESS
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Ac. Coronary Thrombosis</u>			<u>Instant</u>
420. Antecedent cause(s) (b) <u>Arteriosclerotic Cardio-Vascular, yes</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1942, to Oct 24, 1958, that I last saw the deceased alive on Oct 18, 1958, and that death occurred at 6 P. m., from the causes and on the date stated above.

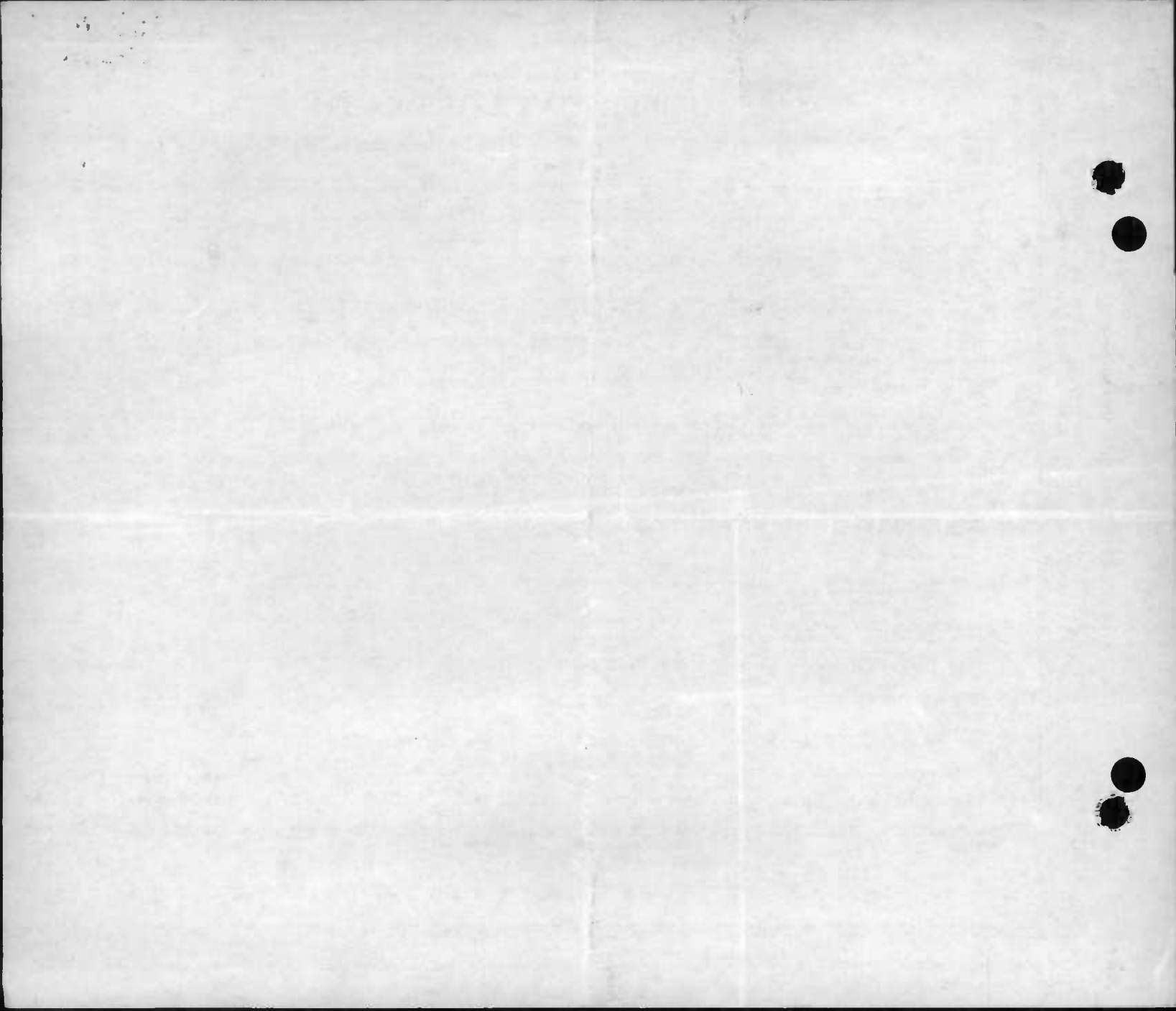
SIGNATURE (Degree or title) Dr. William Klamans MD ADDRESS 31 Southgate Ln DATE SIGNED 10/25/58

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Oct 25, 1958</u>	NAME OF CEMETERY OR CREMATORY <u>County Home</u>	LOCATION (City, town, or county) <u>Edgewater, Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>OCT 28 '58</u>	REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	24. FUNERAL DIRECTOR <u>T A Hauldesty + Son</u>		ADDRESS <u>Galesville, Md</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10849

CERTIFICATE OF DEATH

10888

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2008 McEweny St #5</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen. Hosp.</u>				d. STREET ADDRESS <u>Balto 31014</u>			
3. NAME OF DECEASED (Type or print) <u>Alice</u> First <u>Stampf</u> Middle <u></u> Last <u></u>				4. DATE OF DEATH <u>Oct. 23</u> 19 <u>50</u> Month <u></u> Day <u></u> Year <u></u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 22 1880</u> yrs. <u>27</u>	
9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Thomas Byrne</u>				14. MOTHER'S MAIDEN NAME <u>Margaret McCortley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>Mr. Joseph V. Stumpf-Rt. #2-Box 684-Severna Pk. Md.</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 420.1 DUE TO (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Gen. Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1958</u> , 19 <u>58</u> , to <u>1950</u> , 19 <u>50</u> , that I lost saw the deceased alive on <u>23</u> 19 <u>50</u> , and that death occurred at <u>940</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.				ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>10-23-50</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>				<u>Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/27/58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner & Sons</u> ADDRESS <u>Balto - 12 Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 27 58</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10889

Reg. Dist. No.

10850

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>512 State St.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> d. STREET ADDRESS <u>512 State St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>LLOYD</u> First <u>Wellington</u> Middle <u>Sullivan</u> Last		4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1958</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>8-24-1916</u>		9. AGE (In years last birthday) <u>42</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. U. S. N.</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wellington Sullivan</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Jett</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> 16. SOCIAL SECURITY NO. <u>1935-1955</u>				17. INFORMANT <u>Ernest J. Sullivan</u> Address <u>1117 Lylabue Annapolis Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4344</u> DUE TO <u>Cardiac Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>E. L. N. HAKST</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>10-18-58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Oct 22-58</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>				22d. LOCATION (City, town, or county) <u>Arlington</u> (State) <u>Va</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>				ADDRESS <u>Smo Annapolis Md.</u>				24a. REC'D BY REGISTRAR <u>ACT 2 2 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10890

Reg. Dist. No.

10851

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Annapolis Md.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Household</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. LENGTH OF STAY IN 1b <u>Suffolk Va.</u> 89X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Thomas</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>10</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1915</u> 43 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Brownsville S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>D.K.</u>		14. MOTHER'S MAIDEN NAME <u>D.K. ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mrs. Rebecca Thomas</u>		Address <u>Suffolk Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>drowning</u> 851X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Boat swamped - Severn River</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10-7</u> 1958	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Severn River</u>	20f. (City or town) <u>Alco Md.</u> (County) <u>Alco Md.</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Hubbard</u>		DATE SIGNED <u>10-7-58</u>	
EXAMINER'S NAME (Type) <u>E. L. Hubbard</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>SEPT 10-18-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Severn River</u>	22d. LOCATION (City, town, or county) <u>SUFFOLK</u> (State) <u>VA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. ...</u>		24a. REC'D BY REGISTRAR <u>Oct 10 58</u> 24b. REGISTRAR'S SIGNATURE <u>...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2000

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 2,3,5,6,7,11,12,10,13,14,15 Filing 255

10891

10852 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A.</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		3V01.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home Wood Conv Home</u>				STREET ADDRESS (If rural give location) <u>16 S. Wolfe Street</u>			
3. NAME OF DECEASED (Type or Print) <u>FRANCIS</u> (First) <u>Weisenbach</u> (Last)				4. DATE OF DEATH (Month) <u>Oct</u> (Day) <u>23</u> (Year) <u>1958</u>			
SEX <u>Female</u>	6. COLOR OR RACE <u>W. US</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH		9. AGE last birthday yrs.		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>??</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME <u>(First name unknown)Gottlieb</u>				14. MOTHER'S MAIDEN NAME <u>Bernadine (Last name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>HYPERTENSIVE VASCULAR DISEASE</u>				<u>5 YEARS</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>15 SEPT, 1955</u> , to <u>24 OCT, 1958</u> , that I last saw the deceased alive on <u>23 OCT, 1958</u> , and that death occurred at <u>11:58 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward A. Beck</u>		M.D. <u>41 Southgate Circle Annapolis</u>		DATE SIGNED <u>10/24/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>10-25-58</u>		NAME OF CEMETERY OR CREMATORY <u>of Md.</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>William S. Hines</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Beebe</u>		ADDRESS <u>W. Argon. Md.</u>	
DATE <u>OCT 30 '58</u>							

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

10906
Item 13, Film G234, 10/7/58 fcy Item 9, Film G234, 10/9/58
10906 Items 13, 14 Film G234 10-20-58 et fcy
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10892

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Beach Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>9 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1 CEDAR AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARVIN</u> <u>X</u> <u>White</u>		4. DATE OF DEATH Month Day Year <u>Oct.</u> <u>1</u> <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 1 1906</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Arvin White</u>		14. MOTHER'S MAIDEN NAME <u>ELEANOR Courtney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>578-10-5462</u>	
17. INFORMANT <u>MARY C. White</u>		Address <u>AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>3 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>(Prev. physician - Dr. Page 5th)</u> that I last saw the deceased alive on <u>(DIED IN SLEEP)</u> and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>PRINCE-FREDERICK, Md.</u> DATE SIGNED <u>10-1-58</u>			
ACTUAL SIGNATURE <u>Merle L. Gibson Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>MERLE L. GIBSON, JR.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-3-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Ft Myer, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10893

10853

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>U. S. General</u>		d. STREET ADDRESS <u>1815 Bay Ridge Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>H.</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>10</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1905</u> <u>4-4-1905</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician U.S.N.A. Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Annapolis Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Williams</u>		14. MOTHER'S MAIDEN NAME <u>Ida Sewell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Margaret M. Williams #2</u>	
17. INFORMANT Address <u>Margaret M. Williams #2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Ac. Myocardial Infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> ? (c) <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 25</u> , 1958, to <u>Oct 25</u> , 1958, that I last saw the deceased alive on <u>Oct 25</u> , 1958, and that death occurred at <u>403P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D.		ADDRESS (Street, city or town, state) <u>31 Southgate Ln Annapolis Md</u>	
DATE SIGNED <u>10/27/58</u>			
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-29-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sins</u> ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 30 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of toxicologist	
22. Signature of bacteriologist		23. Signature of virologist		24. Signature of epidemiologist	
25. Signature of public health nurse		26. Signature of health visitor		27. Signature of social worker	
28. Signature of psychologist		29. Signature of psychiatrist		30. Signature of sociologist	
31. Signature of anthropologist		32. Signature of linguist		33. Signature of geographer	
34. Signature of historian		35. Signature of archaeologist		36. Signature of paleontologist	
37. Signature of numismatist		38. Signature of philologist		39. Signature of lexicographer	
40. Signature of grammarian		41. Signature of rhetorician		42. Signature of logician	
43. Signature of metaphysician		44. Signature of epistemologist		45. Signature of ethicist	
46. Signature of political philosopher		47. Signature of economist		48. Signature of sociologist	
49. Signature of psychologist		50. Signature of psychiatrist		51. Signature of sociologist	
52. Signature of anthropologist		53. Signature of linguist		54. Signature of geographer	
55. Signature of historian		56. Signature of archaeologist		57. Signature of paleontologist	
58. Signature of numismatist		59. Signature of philologist		60. Signature of lexicographer	
61. Signature of grammarian		62. Signature of rhetorician		63. Signature of logician	
64. Signature of metaphysician		65. Signature of epistemologist		66. Signature of ethicist	
67. Signature of political philosopher		68. Signature of economist		69. Signature of sociologist	
70. Signature of psychologist		71. Signature of psychiatrist		72. Signature of sociologist	
73. Signature of anthropologist		74. Signature of linguist		75. Signature of geographer	
76. Signature of historian		77. Signature of archaeologist		78. Signature of paleontologist	
79. Signature of numismatist		80. Signature of philologist		81. Signature of lexicographer	
82. Signature of grammarian		83. Signature of rhetorician		84. Signature of logician	
85. Signature of metaphysician		86. Signature of epistemologist		87. Signature of ethicist	
88. Signature of political philosopher		89. Signature of economist		90. Signature of sociologist	
91. Signature of psychologist		92. Signature of psychiatrist		93. Signature of sociologist	
94. Signature of anthropologist		95. Signature of linguist		96. Signature of geographer	
97. Signature of historian		98. Signature of archaeologist		99. Signature of paleontologist	
100. Signature of numismatist		101. Signature of philologist		102. Signature of lexicographer	
103. Signature of grammarian		104. Signature of rhetorician		105. Signature of logician	
106. Signature of metaphysician		107. Signature of epistemologist		108. Signature of ethicist	
109. Signature of political philosopher		110. Signature of economist		111. Signature of sociologist	
112. Signature of psychologist		113. Signature of psychiatrist		114. Signature of sociologist	
115. Signature of anthropologist		116. Signature of linguist		117. Signature of geographer	
118. Signature of historian		119. Signature of archaeologist		120. Signature of paleontologist	
121. Signature of numismatist		122. Signature of philologist		123. Signature of lexicographer	
124. Signature of grammarian		125. Signature of rhetorician		126. Signature of logician	
127. Signature of metaphysician		128. Signature of epistemologist		129. Signature of ethicist	
130. Signature of political philosopher		131. Signature of economist		132. Signature of sociologist	
133. Signature of psychologist		134. Signature of psychiatrist		135. Signature of sociologist	
136. Signature of anthropologist		137. Signature of linguist		138. Signature of geographer	
139. Signature of historian		140. Signature of archaeologist		141. Signature of paleontologist	
142. Signature of numismatist		143. Signature of philologist		144. Signature of lexicographer	
145. Signature of grammarian		146. Signature of rhetorician		147. Signature of logician	
148. Signature of metaphysician		149. Signature of epistemologist		150. Signature of ethicist	
151. Signature of political philosopher		152. Signature of economist		153. Signature of sociologist	
154. Signature of psychologist		155. Signature of psychiatrist		156. Signature of sociologist	
157. Signature of anthropologist		158. Signature of linguist		159. Signature of geographer	
160. Signature of historian		161. Signature of archaeologist		162. Signature of paleontologist	
163. Signature of numismatist		164. Signature of philologist		165. Signature of lexicographer	
166. Signature of grammarian		167. Signature of rhetorician		168. Signature of logician	
169. Signature of metaphysician		170. Signature of epistemologist		171. Signature of ethicist	
172. Signature of political philosopher		173. Signature of economist		174. Signature of sociologist	
175. Signature of psychologist		176. Signature of psychiatrist		177. Signature of sociologist	
178. Signature of anthropologist		179. Signature of linguist		180. Signature of geographer	
181. Signature of historian		182. Signature of archaeologist		183. Signature of paleontologist	
184. Signature of numismatist		185. Signature of philologist		186. Signature of lexicographer	
187. Signature of grammarian		188. Signature of rhetorician		189. Signature of logician	
190. Signature of metaphysician		191. Signature of epistemologist		192. Signature of ethicist	
193. Signature of political philosopher		194. Signature of economist		195. Signature of sociologist	
196. Signature of psychologist		197. Signature of psychiatrist		198. Signature of sociologist	
199. Signature of anthropologist		200. Signature of linguist		201. Signature of geographer	
202. Signature of historian		203. Signature of archaeologist		204. Signature of paleontologist	
205. Signature of numismatist		206. Signature of philologist		207. Signature of lexicographer	
208. Signature of grammarian		209. Signature of rhetorician		210. Signature of logician	
211. Signature of metaphysician		212. Signature of epistemologist		213. Signature of ethicist	
214. Signature of political philosopher		215. Signature of economist		216. Signature of sociologist	
217. Signature of psychologist		218. Signature of psychiatrist		219. Signature of sociologist	
220. Signature of anthropologist		221. Signature of linguist		222. Signature of geographer	
223. Signature of historian		224. Signature of archaeologist		225. Signature of paleontologist	
226. Signature of numismatist		227. Signature of philologist		228. Signature of lexicographer	
229. Signature of grammarian		230. Signature of rhetorician		231. Signature of logician	
232. Signature of metaphysician		233. Signature of epistemologist		234. Signature of ethicist	
235. Signature of political philosopher		236. Signature of economist		237. Signature of sociologist	
238. Signature of psychologist		239. Signature of psychiatrist		240. Signature of sociologist	
241. Signature of anthropologist		242. Signature of linguist		243. Signature of geographer	
244. Signature of historian		245. Signature of archaeologist		246. Signature of paleontologist	
247. Signature of numismatist		248. Signature of philologist		249. Signature of lexicographer	
250. Signature of grammarian		251. Signature of rhetorician		252. Signature of logician	
253. Signature of metaphysician		254. Signature of epistemologist		255. Signature of ethicist	
256. Signature of political philosopher		257. Signature of economist		258. Signature of sociologist	
259. Signature of psychologist		260. Signature of psychiatrist		261. Signature of sociologist	
262. Signature of anthropologist		263. Signature of linguist		264. Signature of geographer	
265. Signature of historian		266. Signature of archaeologist		267. Signature of paleontologist	
268. Signature of numismatist		269. Signature of philologist		270. Signature of lexicographer	
271. Signature of grammarian		272. Signature of rhetorician		273. Signature of logician	
274. Signature of metaphysician		275. Signature of epistemologist		276. Signature of ethicist	
277. Signature of political philosopher		278. Signature of economist		279. Signature of sociologist	
280. Signature of psychologist		281. Signature of psychiatrist		282. Signature of sociologist	
283. Signature of anthropologist		284. Signature of linguist		285. Signature of geographer	
286. Signature of historian		287. Signature of archaeologist		288. Signature of paleontologist	
289. Signature of numismatist		290. Signature of philologist		291. Signature of lexicographer	
292. Signature of grammarian		293. Signature of rhetorician		294. Signature of logician	
295. Signature of metaphysician		296. Signature of epistemologist		297. Signature of ethicist	
298. Signature of political philosopher		299. Signature of economist		300. Signature of sociologist	

100-6-15-1

10854

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>W.D. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>W.D. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>W.D. General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jeremiah Wynn</u> First Middle Last		4. DATE OF DEATH <u>10 21 1958</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-1911</u> yrs. Months Days Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar tender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Annapolis Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pell City Ala.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Kirk Wynn</u>		14. MOTHER'S MAIDEN NAME <u>Loubertha Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>214-12-1434</u>	
17. INFORMANT <u>Mary Wynn</u>		Address <u>17 College Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pancreatitis</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>7 da</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/16</u> , 19 <u>58</u> , to <u>10/21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/15</u> , 19 <u>58</u> , and that death occurred at <u>2:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Geoburd K. Peeler</u> M.D.		ADDRESS (Street, city or town, state) <u>121 Cathedral St.</u> DATE SIGNED <u>10/23/58</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>		<u>Annapolis, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>10-25-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Keesett</u>		ADDRESS <u>108 Wash St. Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		DATE <u>10/28/58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10000

U.S.A.
MAY 1964
BOLIND

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text elements like 'U.S.A.' and 'BOLIND'.

Vertical text on the right margin, likely a filing or processing stamp, containing the words "RECEIVED" and "FILED".

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10895

10855

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNE ARUNDEL</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6 GOODRICH AVE.</u>		d. STREET ADDRESS <u>6 GOODRICH AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELOISE J. ZACHARIAS</u>		4. DATE OF DEATH Month Day Year <u>10 7 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-1909</u>
9. AGE (In years last birthday) yrs. <u>49</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>49</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ROBERT JARRELL</u>		14. MOTHER'S MAIDEN NAME <u>S. EVA PRITCHETT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>D. J. ZACHARIAS</u>	
17. INFORMANT Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>170x</u> * DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of breast</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 yr.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-2-58</u> , to <u>10-7-58</u> , that I last saw the deceased alive on <u>10-6-58</u> , 19 <u>58</u> , and that death occurred at <u>5 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>10-7-58</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-9-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lyle & Sons</u>		24a. REC'D BY REGISTRAR <u>Annapolis, Md.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>OCT 14 '58</u>	

